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VHA HANDBOOK

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MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAM
(MH RRTP)

- 1. PURPOSE.** This Veterans Health Administration (VHA) Handbook establishes the procedures and reporting requirements for the Mental Health Residential Rehabilitation Treatment Program (MH RRTP) bed level of care.
- 2. SUMMARY OF CHANGES.** The amendments to this VHA Handbook further define and clarify the procedures relating to MH RRTPs.
- 3. RELATED ISSUES.** VHA Directive 1162.
- 4. RESPONSIBLE OFFICE.** The Office of Mental Health Services (116) in the Office of Patient Care Services is responsible for the contents of this Handbook. Questions may be referred to (202) 461-7306.
- 5. RESCISSIONS.** VHA Handbook 1162.02, dated May 26, 2009 is rescinded.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of December 2015.

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Under Secretary for Health

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MENTAL HEALTH RESIDENTIAL REHABILITATION TREATMENT PROGRAM (MH RRTP)

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides the procedures and reporting requirements for the Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP) bed level of care including: Domiciliary Residential Rehabilitation Treatment Program (DRRTP), Domiciliary Care for Homeless Veterans (DCHV), Psychosocial Residential Rehabilitation Treatment Program (PRRTP), Substance Abuse Residential Rehabilitation Treatment Program (SARRTP), Post-Traumatic Stress Disorder (PTSD) Residential Rehabilitation Treatment Program (PTSD-RRTP), and Compensated Work Therapy (CWT)-Transitional Residence (TR) Program.

2. BACKGROUND

a. The Domiciliary Care Program is the Department of Veterans Affairs (VA) oldest health care program. Established through legislation passed in the late 1860's, the Domiciliary purpose was to provide a home for disabled volunteer soldiers of the Civil War. Domiciliary care was initially established to provide services to economically-disadvantaged Veterans, and it remains committed to serving that group. The Domiciliary has evolved from a "Soldiers' Home" to become an active clinical rehabilitation and treatment program for male and female Veterans. Domiciliary care is an integral component of VHA's mental health continuum of care.

b. VA established the PRRTP bed level of care in 1995. This distinct level of mental health residential care is appropriate for Veterans with mental illnesses or addictive disorders who require additional structure and support to address multiple and severe psychosocial deficits, including homelessness and unemployment. VA recognized the need for psychiatric and psychotherapeutic treatment and symptom reduction of mental and addictive disorders, and PRRTP provided the opportunity to improve functional status while providing psychosocial rehabilitation focusing on the patient's strengths. This rehabilitative approach recognizes that persons with mental illness and addictive disorders can achieve their goals for healthy and productive lives. MH RRTPs are designed to provide comprehensive treatment and rehabilitative services meant to improve the quality of life and diminish reliance upon more resource-intensive forms of treatment.

c. In 2005, DRRTP became fully integrated with other residential rehabilitation and treatment programs of the Office of Mental Health Services. The MH RRTP bed service includes the following models of residential care: DRRTP, DCHV, PRRTP, SARRTP, PTSD-RRTP, General Domiciliary, Domiciliary Substance Abuse (SA), Domiciliary PTSD, and CWT-TR.

d. MH RRTPs may provide the treatment program within the MH RRTP itself, or Veterans in MH RRTPs may participate in an intensive regimen of outpatient services, such as: Intensive Outpatient Substance Use Disorder (SUD) Programs, PTSD, Psychosocial Rehabilitation Recovery Centers (PRRC), and vocational rehabilitation, which are then augmented by the MH

RRTP component of care. In all cases, the residential component emphasizes incorporation of clinical treatment gains into a lifestyle of self-care and personal responsibility. Treatment intensity, environmental structures, milieu, and type of supervision vary based on the population served, and the need to be relevant to the diversity of the population, (e.g., age, ethnicity, and culture). There are two basic models for residential rehabilitation programming.

(1) **All Inclusive Residential Model.** In the all-inclusive residential model, staff dedicated to the MH RRTP unit provide virtually all treatment and rehabilitative services, and do so exclusively for the Veterans in those beds. This model may provide advantages for programming which is tailored specifically for group treatment approaches. It may also be used more often for programs that are targeting a higher acuity of illness and are, therefore, providing higher intensity of care.

(2) **Supportive Residential Model.** This program structure provides a supportive residential component to augment intensive treatment provided through the Ambulatory Care System, such as: the Intensive Outpatient SUD Program, Day Treatment Program, PRRC, CWT, and PTSD program. It is designed to minimize risk and maximize the benefit of the ambulatory care services provided to Veterans whose health or lifestyle necessitates a supervised, structured environment while receiving care, or those requiring comprehensive rehabilitation to learn and practice new behaviors.

e. **Therapeutic Community**

(1) MH RRTPs utilize therapeutic communities that enhance the provision of residential rehabilitation and treatment services. MH RRTP therapeutic communities utilize both peer and professional support services in a structured, residential environment that fosters personal growth leading to personal accountability. The therapeutic community emphasizes the integration of a resident within the community and views the community as the model for change. This mutual self-help model requires residents to actively participate in their own treatment and the treatment of others using the community as the model.

(2) MH RRTPs demonstrate the use of the mutual self-help model through:

- (a) Adhering to program rules.
- (b) Adhering to existing schedules.
- (c) Adhering to behavioral expectations of the community.
- (d) Accepting of responsibility for self, applicable others, and the health of the community.
- (e) Positively influencing other members of the community by teaching and modeling appropriate behaviors in program functions, activities, and the community itself.
- (f) Providing honest feedback and guidance to other members of the community that leads to discourse in a community forum.

- (g) Demonstrating empathy and genuine concern for other members of the community.

3. AUTHORITY

Title 38 United States Code (U.S.C.), Sections 1710 and 8110 authorize VA to provide Domiciliary care. Title 38 U.S.C., § 1710 authorizes VA to provide inpatient care. Title 38

U.S.C. § 2032 authorizes the CWT-TR Program. Title 38 Code of Federal Regulations (CFR) 17.46, 17.47, and 17.48 provides eligibility criteria for DRRTP and CWT-TR programs. **NOTE:** *This Handbook does not replace those source documents; however, it is essential that source documents be read and understood to ensure uniform and appropriate application.*

4. DEFINITIONS

A MH RRTP provides residential rehabilitative and clinical care to eligible Veterans who have a wide range of problems, illnesses, or rehabilitative care needs which can be mental health, SUD, co-morbid medical, homelessness, vocational, educational, or social. The term MH RRTP refers to the bed category and includes the following models:

a. **Domiciliary Residential Rehabilitation Treatment Programs (DRRTP).** A DRRTP provides a residential level of care for Veteran populations including medical, psychiatric, SUD, PTSD, and homelessness. DRRTPs provide a 24-hours-per-day, 7 days-per-week (24/7) structured and supportive residential environment as a part of the rehabilitative treatment regime. DRRTPs are larger residential programs with multiple units serving various patient populations. Bed sections within a DRRTP may include DCHV, General Domiciliary, Domiciliary SA, Domiciliary PTSD, and Health Maintenance Domiciliary.

b. **Domiciliary Care for Homeless Veterans (DCHV).** A DCHV provides a residential level of care for a homeless Veteran population. DCHVs provide a 24/7 structured and supportive residential environment as a part of the rehabilitative treatment regime. A DCHV may be a stand alone program or a unit within a larger DRRTP. **NOTE:** *All DCHV programs must utilize treating specialty code #37.*

c. **Health Maintenance Domiciliary.** Health Maintenance Domiciliary beds provide a residential level of care for Veteran populations including medical, psychiatric, SUD, PTSD, and homelessness. Health Maintenance Domiciliary beds provide a structured and supportive residential environment 24/7 as a part of the rehabilitative treatment regime. Health Maintenance Domiciliary beds focus on symptom reduction and stabilization as part of the rehabilitative approach to facilitating community integration. A Health Maintenance Domiciliary program may be a stand alone unit or part of a larger DRRTP; when part of a larger DRRTP, the beds are equivalent to the General Domiciliary bed category. **NOTE:** *All Health Maintenance Domiciliary programs must utilize treating specialty code # 85.*

d. **General Domiciliary (General Dom) or Psychosocial Residential Rehabilitation Treatment Programs (PRRTP).** These programs provide a residential treatment level of care for a general Veteran population including co-morbid medical, psychiatric, SUD, PTSD, and homelessness. General Doms and PRRTPs provide a 24/7 structured and supportive residential environment as a part of the rehabilitative treatment regime. General Dom beds are a part of a

larger DRRTP while PRRTPs are a stand alone unit. **NOTE:** All General Dom programs must utilize treating specialty code 85. All PRRTP programs must utilize treating specialty code #1K.

e. **Domiciliary PTSD (Dom PTSD) or Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program (PTSD-RRTP).** These programs provide a residential level of care to Veterans with PTSD including Military Sexual Trauma (MST). Both Dom PTSD and PTSD-RRTP provide a 24/7 structured and supportive residential environment as a part of the PTSD rehabilitative treatment regime. A Dom PTSD may be part of a larger DRRTP while a PTSD-RRTP is a stand alone unit (formerly known as the acronym PRRP). **NOTE:** All Dom PTSD programs must utilize treating specialty code 88. All PTSD-RRTP programs must utilize treating specialty code #1L.

f. **Domiciliary SA (Dom SA) or Substance Abuse Residential Rehabilitation Treatment Program (SARRTP).** These programs provide a residential level of care to Veterans with SUD. **NOTE:** SUDs encompass the family of alcohol and other drug-use illnesses that meet diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). Dom SA and SARRTP provide a 24/7 structured and supportive residential environment as a part of the SUD rehabilitative treatment regime. Dom SA beds may be part of a larger DRRTP while a SARRTP is a stand alone program. **NOTE:** All Dom SA programs must utilize treating specialty code 86. All SARRTP programs must utilize treating specialty code #1M.

g. **Compensated Work Therapy (CWT)-Transitional Residence (TR).** A general CWT- TR is not targeted exclusively for any particular mental health population and provides TR services. General CWT-TR offers therapeutic work-based residential rehabilitation services designed to facilitate successful community reintegration. **NOTE:** All CWT-TR programs must utilize treating specialty code #39.

5. MISSION, GOALS, AND OBJECTIVES

a. **Mission.** The MH RRTP mission is to provide state-of-the-art, high-quality residential rehabilitation and treatment services for Veterans with multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. The MH RRTP identifies and addresses goals of rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specific treatment of medical conditions, mental illnesses, addictive disorders, and homelessness.

b. **Goal.** MH RRTP's goal is to provide opportunities for Veterans to achieve and maintain their highest level of independent community integration through the provision of residential services designed for improved functional status, sustaining rehabilitation gains, disability management, recovery, and breaking the cycle of recidivism.

c. **Objectives.** Objectives of MH RRTP are to:

(1) Provide residential rehabilitation and treatment services that focus on the Veteran's strengths, abilities, needs, and preferences rather than on illness and symptoms.

(2) Provide residential rehabilitation and treatment services utilizing a therapeutic community based on peer and professional supports in a structured and supervised setting.

(3) Provide rehabilitation and treatment services that address medical conditions, mental illness, addiction, and psychosocial deficits.

(4) Facilitate the transition to safe, affordable, and appropriate community housing.

(5) Assist Veterans in choosing, accessing, and utilizing the community and natural supports needed to be independent, self-supporting, and successful in their individual recovery.

6. SCOPE

a. VHA policy establishes a MH RRTP residential level of inpatient bed care that is distinct from medium and high-intensity inpatient psychiatry beds. The MH RRTP provides a 24-hour therapeutic setting utilizing a milieu of peer and professional support. This program provides a strong emphasis on psychosocial rehabilitation and recovery services that instill personal responsibility to achieve optimal levels of independence upon discharge to independent or supportive community living.

b. Given the distinct mission to serve Veterans with multiple and severe deficits, a MH RRTP must not be used as a simple substitute for community housing or as VA lodging or Hoptel facility. Since, VA lodging or Hoptel facilities do not provide the necessary structure, programming, and support, they are not an appropriate alternative or replacement for an MH RRTP.

c. MH RRTP beds are distinct from a sub-acute or intermediate psychiatry beds that generally are co-located or integrated with an acute unit, and which provide short-term discharge planning. MH RRTP's provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home beds as Veterans in MH RRTPs do not require bedside nursing care and are generally capable of self-care.

d. All MH RRTPs contain the following program elements: design (see par. 12), location (see par. 13), program structure (see par. 14), staffing requirements (see par. 15), admission (see par. 16), screening (see par. 17), required health records (see par. 18), history and physical (see par. 19), assessment (see par. 20), rehabilitation and treatment plan (see par. 21), discharge (see par. 22), residential costs and workload capture (see par. 23), environment of care (see par. 24), vocational rehabilitation and employment services (see par. 25), suicide risk assessment and prevention (see par. 26), and safe medication management (see par. 27).

e. **Accreditation.** All MH RRTPs must be accredited under The Joint Commission (TJC) and Commission on Accreditation of Rehabilitation Facilities (CARF) Behavioral Health (BH) and Residential Treatment (RT) standards for BH Care (24-hour settings). All types of CWT-TRs must be accredited under CARF Standards for BH Psychosocial-Community Housing in addition to the TJC BH and RT standards.

7. RESPONSIBILITIES OF THE OFFICE OF MENTAL HEALTH SERVICES (OMHS)

The VA Central Office, OMHS, Homeless and Residential Rehabilitation and Treatment Programs, is responsible for:

- a. Developing national policy and procedures for MH RRTPs based on relevant laws, regulations, and VHA's mission, goals, and objectives.
- b. Providing consultation and guidance to Veterans Integrated Service Networks (VISN) and VA medical centers for the development and operation of MH RRTPs.
- c. Leading the MH RRTP Field Advisory Board (FAB), which advises the Director of Residential Rehabilitation Services on policy and procedures related to MH RRTPs.
- d. Reviewing all medical center MH RRTP bed and program change proposals and providing comments to the Deputy Under Secretary for Health for Operations and Management (10N).

8. RESPONSIBILITIES OF THE VISN DIRECTOR

Each VISN Director is responsible for ensuring:

- a. That MH RRTPs are operated in compliance with relevant Public Laws, regulations, and VHA policy and procedures.
- b. Access to MH RRTPs by maintaining adequate bed capacity including capacity for women Veterans.
- c. That the VISN has residential care programs able to meet the needs of women Veterans and Veterans with a Serious Mental Illness (SMI), PTSD, MST, SUD, Homelessness, and Dual Diagnosis either through special residential programs or specific tracks in residential care programs.
- d. That Veterans who require RRTPs have timely access to these residential care programs as medically necessary to meet Veterans needs for specialized residential, intensive MH treatment, and rehabilitation services.

9. RESPONSIBILITIES OF THE NETWORK HOMELESS COORDINATOR (NHC)

Each NHC is responsible for:

- a. Coordinating VISN-wide residential rehabilitation reports, assessments, evaluations, and follow-up actions for implementing VHA policy and procedures.
- b. Ensuring that MH RRTP coordinates and integrates services for homeless Veterans with local homeless coordinators.

c. Ensuring inclusion of all MH RRTP residents in the yearly Community Homeless Assessment, Local Education and Networking Groups (CHALENG) survey.

d. Acting as a liaison between OMHS, the VISN, facility leadership, Mental Health and Behavioral Sciences (MH&BS) departmental leadership, and the Domiciliary Chief or MH RRTP Program Manager.

10. RESPONSIBILITIES OF THE FACILITY DIRECTOR

Each facility Director is responsible for:

a. Providing and maintaining program oversight to ensure quality services and compliance with VHA policy and procedures. Special attention must be given to addressing the unique needs of special populations, including women Veterans.

b. Ensuring the timely completion of all mandated reporting, monitoring, and accreditation requirements.

c. Providing a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances the recovery efforts of the Veteran and addresses the unique environmental and safety needs of women Veterans (see pars. 24 and 28)

d. Ensuring the financial management and fiscal stability of the MH RRTP, including those utilizing Veteran program fees to fund housing-related expenses.

e. Ensuring consultation with the OMHS prior to bed or program changes as outlined in current VHA bed control policy and current VHA MH program change policy.

f. Providing appropriate support and resources to ensure the MH RRTP is able to accomplish its stated mission, goals, and objectives.

g. Maintaining compliance with VA and accrediting bodies environment of care standards (see par. 24).

h. Requiring specific training and competencies for managers and clinicians to address the mental health needs specific to treatment population and gender-based needs.

i. Ensuring that residential and mental health services are provided to women Veterans at a level that is equivalent to that provided male Veterans at each facility.

j. Ensuring that an MH RRTP, operating in partnership with a community organization, provides safe, efficient, and effective services comparable to an on-station program and it is in compliance with the procedures in this Handbook.

11. RESPONSIBILITIES OF THE DOMICILIARY CHIEF OR MH RRTP PROGRAM MANAGER

The Domiciliary Chief or MH RRTP Program Manager is responsible for:

- a. Managing all clinical and administrative operations of the MH RRTP to ensure the safe, efficient, and effective provision of rehabilitation and treatment services.
- b. Maintaining an 85 percent bed occupancy rate.
- c. Ensuring the MH RRTP is operated in compliance with all VHA policies and procedures.
- d. Completing all mandated reporting, monitoring, evaluation, and accreditation requirements relevant to the MH RRTP.
- e. Establishing procedures for the ongoing monitoring and evaluation of the effectiveness of all program activities.
- f. Ensuring the collaboration and integration of treatment and rehabilitation services with MH, primary care, and other specialty services.
- g. Developing partnerships with community providers to facilitate outreach and discharge planning.
- h. Reporting significant and adverse events and program changes, including changes in mission, number of beds, or number of staff to the Director, Residential Rehabilitation, OMHS, within 24 hours of any incident.
- i. Developing written procedures for detecting contraband brought onto the unit.
- j. Developing a safe medication management policy (see App. C).
- k. Coordinating provisions for vocational rehabilitation and employment services (see par. 25).

12. DESIGN

The MH RRTP model is designed for maximum flexibility of program design. This flexibility in MH RRTP design supports the establishment of more than one of a specific type of MH RRTP at a medical center in order to most efficiently meet the rehabilitative needs of a diverse Veteran population.

- a. All MH RRTPs must design services for the treatment of Veterans with co-occurring disorders. Treatment for co-occurring conditions include: concurrent interventions addressing SA, MH, and medical disorders that contribute to deficits in functioning.

b. In MH RRTPs, treatment, rehabilitation, and psychosocial programming may range from relatively short-term care of limited focus, (e.g., less than 30 days and targeted primarily towards diagnosis-specific education, counseling, and symptom management) to long-term, comprehensive rehabilitation (e.g., exceeding 1 year and including a full-range of psychosocial services, such as life-skills training, social learning, vocational rehabilitation therapy, CWT, etc.).

c. Within various types of MH RRTPs, specific sub-populations may be targeted, necessitating specialized staff and rehabilitative approaches. All MH RRTPs must incorporate programming specific to the Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) Veteran population. There may also be specific MH RRTP “tracks” within targeted populations, (e.g., a SA residential program designed for Veterans with dual diagnoses, and another for Veterans with an addictive disorder only, or another with a strong psychosocial rehabilitation component addressing issues of work and independent living skills). For example, a MH RRTP might have a shorter length of stay (LOS) concentrating on psychotherapy and education for Veterans’ targeted needs, while the same MH RRTP might provide more comprehensive rehabilitative services and a longer LOS for Veterans with more extensive needs. *NOTE: This model may help smaller medical centers in accommodating diverse needs within limited space and personnel resources.*

13. LOCATION

a. MH RRTPs may be established either on VA medical center grounds, or in community facilities owned, leased, or otherwise acquired by VA. Regardless of the location of MH RRTP beds, they must be designated as official VA beds in accordance with VHA bed control policy and reported on the Gains and Losses (G&L) statement of the associated VA health care system or medical center.

(1) MH RRTPs, whether on-station or located in the community, are distinct from Health Care for Homeless Veterans (HCHV) contract care programs where VA contracts with a community organization to provide housing and supportive services. Medical centers may establish MH RRTPs through a lease with a community organization. In these situations, VA may contract with the community organization for non-clinical services. However, VA staff is responsible for providing all clinical services.

(2) The residence must be a separate and distinct unit where only Veterans of the MH RRTP may reside. Through contracts with VA, the community organization may provide coverage staff to monitor the residence on evenings, nights, and weekends, and other services, such as meals, housekeeping, and transportation. In all other respects, a MH RRTP located in the community facility must be operated in a similar manner to an on-station program, and be in compliance with VHA policies and procedures including adherence to all relevant VA and accrediting bodies environment of care standards.

b. When operating a MH RRTP through a contract with a community organization, the following must be implemented:

(1) The community organization's staff that provides services to Veterans must have appropriate training and qualifications to provide a safe, secure, confidential, and structured residential environment that address the needs of the Veteran.

(2) The coverage staff in the community organization must have the same competencies as VA staff in an on-station MH RRTP.

(3) There must be a process in place for VA staff to provide guidance to the community organization to ensure the continuity of care, particularly during evenings, nights, and weekends.

(4) There must be a plan in place to provide for the availability of appropriate VA staff at all times.

(5) The performance of the community organization must be evaluated annually. This evaluation must include:

(a) The quality of the environment of care, performance of the contracted staff, and other specific elements contained in the contract for services.

(b) A corrective action plan for noted deficits and any required follow-up until completion.

***NOTE:** This Handbook can be used as a guide in developing an evaluation. This system must allow VA access to the community organizations records to facilitate appropriate information, which needs to be integrated into the consolidated medical record.*

14. PROGRAM STRUCTURE

a. **Meals.** In most cases, the cost of and preparation of meals is the responsibility of the medical center. In many MH RRTPs, especially those on medical center grounds, Veterans eat in the medical center dining room or in dining rooms at the unit. Where appropriate (for example, in a CWT-TR), preparation of meals in MH RRTPs may be by the Veterans themselves, or by personnel associated with the residence. When Veterans assigned to the MH RRTP are responsible for their own meals, sufficient staff supervision must be provided to ensure Veterans engage in appropriate meal planning, food preparation, sanitation, and safety.

b. **Evening and Weekend Programming.** MH RRTP policy requires a minimum of 4 hours per day of treatment or therapeutic activities, 7 days per week. Programs must provide appropriate therapeutic activities in the evening and on weekends. While the use of appropriate passes that are directly related to the accomplishment of the Veteran's treatment and rehabilitation goals is encouraged, programs may not place all residents on pass for the weekend as a means of meeting the programming goal or due to lack of staffing availability. Evening and weekend activities must have a direct relationship to assisting the Veterans in meeting treatment and rehabilitation goals.

c. **Monitoring.** The Northeast Program Evaluation Center (NEPEC) located at the VA Connecticut Healthcare System at West Haven, CT, monitors initial implementation of MH RRTPs and conducts an annual survey of facilities reporting MH RRTP workload. Outcomes

monitoring, to include measures of efficiency, effectiveness, access, and Veteran satisfaction must be developed at each local program as part of quality improvement initiatives, and must be periodically reviewed for opportunities to improve Veteran outcomes and MH RRTP performance. In addition to the annual NEPEC survey, MH RRTPs are required to fully participate in the NEPEC admission, discharge, and follow-up data collection, and outcome monitoring activities. MH RRTPs are also required to fully participate in the Annual Residential Program Safety and Security Assessment (Report Control Number (RCN) 10-0172). **NOTE:** *The NHC must address MH RRTP performance in an annual Executive Summary in response to the NEPEC and Safety and Security reports.*

d. **Transportation.** When a Veteran is referred for screening or admission to an MH RRTP by another VA facility, transportation at VA expense may be provided to eligible beneficiaries in accordance with Beneficiary Travel (BT) Regulations 38 CFR Part 70 and VHA Handbook 1601B.05. Veterans ineligible for BT with no other means of transportation may be referred to non-VA resources including the Disabled American Veterans (DAV) transportation network, or other local, State, and Federal programs for which they may qualify.

e. **Authorized Absences.** Authorized Veteran absences must be administered in accordance with VHA policy M1, Part 1, Chapter 13, Section II 13.02 and 13.03. **NOTE:** *Veterans are encouraged to make use of authorized absences for therapeutic and rehabilitative purposes.*

(1) Veterans on authorized absence, not to exceed 96 consecutive hours, are considered bed occupants and their beds are reserved. Veterans granted absences in excess of 96 hours are considered absent bed occupants and their beds are not reserved.

(2) While it needs to be utilized only rarely and under unusual circumstances, authorized absence for periods up to 30 days may be granted. An absence cannot extend beyond the due date of the Veteran's annual physical examination.

(3) When a Veteran on authorized absence is admitted to a VA medical center for treatment, the absence is cancelled and the status changed to absent-sick-in-hospital (ASIH), or the Veteran must be discharged from MH RRTP.

(4) Systems of control (e.g., sign-out and sign-in lists) must be designed and implemented to ensure knowledge of the Veterans' whereabouts both to monitor and address individual Veteran safety, and ensure the integrity and security of the program living space.

f. **Stakeholder Committee**

(1) All MH RRTP programs must have a committee whose task is to provide information or viewpoints from individual attendees to the MH RRTP program in its efforts to meet its mission and serve a full-range of Veterans. Membership in this committee must be voluntary, and may come from the ranks of program alumni, VA mental health service providers, community providers, and Veteran consumers (e.g., SMI, women, OEF-OIF Veterans, etc.). The attendees may or may not change from session to session.

(2) The committee must meet on a monthly basis and attendance by the Domiciliary Chief or MH RRTP Program Manager, or a designee, is mandatory. Areas of consideration for the

committee may include, but are not limited to: admission criteria, treatment options offered by the program, and alumni or aftercare activities.

(3) Suggestions made by the committee must be given full consideration by the Domiciliary Chief or MH RRTP Program Manager, who makes the final decision on the implementation of any suggestions.

g. **Missed Appointments**

(1) Services in the MH RRTP may be provided by direct staff on the unit or through ambulatory care clinics and require coordination to ensure the Veteran's participation. The MH RRTP case manager or care coordinator will ensure each Veteran is fully participating in their treatment and rehabilitation services by tracking the Veteran's missed appointments. The MH RRTP treatment team will monitor and address missed appointments with the Veteran on an individual basis.

15. STAFFING REQUIREMENTS

a. MH RRTPs, as a defined clinical care entity, must have adequate staffing to provide safe, effective, and appropriate clinical care. MH RRTPs are organized under the clinical supervision of the facility MH Services.

(1) The MH RRTP Program Manager is responsible for all clinical and administrative operations of the MH RRTP to ensure the safe, efficient, and effective provision of rehabilitation and treatment services. **NOTE:** *The medical center Nurse Executive has responsibility for overall nursing practice.*

(2) The Domiciliary Chief or MH RRTP Program Manager is selected by facility mental health leadership from a clinical discipline including, but not limited to: Psychologist, Social Worker, Nurse, Physician, Physician Assistant (PA), Nurse Practitioner (NP), or Rehabilitation Counselor or Specialist.

b. Each MH RRTP must be staffed by:

(1) An interdisciplinary clinical team or teams of health care professionals and paraprofessionals with the training and expertise needed to provide interventions designed to benefit the Veteran, which may include the resident's family when included in the treatment plan.

(2) Appropriate supporting administrative and clerical staff to allow for efficient operation.

c. Since onsite supervision of MH RRTPs is required 24/7, an employee must be physically present on the unit at all times that Veterans are present on the unit.

(1) In MH RRTPs with multiple floors or buildings, a staff person must be physically present on each floor in each building.

(2) Where there is more than one unit on a floor, a centralized VA staff person may cover both units only if there is open and clear access to each unit and staff can view and hear the operation of both units.

(3) In locations where there is more than one unit on a floor and there are physical barriers between the units, a staff person must be physically present on each unit. Staffing for all positions must be adequate to allow coverage, even in times of staff shortage or absence.

(4) Medical center management must identify appropriate staff to be on call by radio, telephone, or pager at all times.

c. In most MH RRTPs, core staffing includes full-time staff assigned directly to the program and part-time staff from other inpatient or outpatient units who provide treatment and rehabilitation services. For additional staffing requirements for specific specialty care within MH RRTPs refer to:

- (1) PRRTTP staffing guidelines (see subpar. 30e).
- (2) SARRTTP staffing guidelines (see subpar. 31f).
- (3) PTSD-RRTP staffing guidelines (see subpar. 32j).
- (4) CWT-TR staffing guidelines (see par. 34g)

d. **Exceptions for CWT-TR Program**

(1) In the CWT-TRs, a current or “graduate” resident may supervise the residence in lieu of staff. These “House Managers” must have a stable, responsible, caring demeanor, and have leadership qualities, such as effective communication skills and the ability to motivate.

(2) At minimum, House Managers and non-professional staff are to be trained to observe resident behaviors, facilitate a healthy therapeutic environment, (e.g., encourage socialization and participation, and coordinate residential activities), ensure safety, and initiate the call for professional staff intervention.

(3) Professional staff must always be available on an emergency and callback basis.

(4) A graduate of CWT-TR acting as a House Manager must be established as a without compensation (WOC) employee through Human Resource Management Service.

e. Written staffing plans must be developed at each MH RRTP based on policy and guidelines in this Handbook and the minimum core staffing requirements as outlined in Appendices A and B. Individual clinical full-time equivalent (FTE) employee may be adjusted as long as the facility staff to bed ratio is met:

- (1) For programs up to 40 beds: This ratio is to be 1:3.

(2) For programs up to 100 beds: This ratio is to be 1:4.

(3) For programs over 100 beds or Health Maintenance Domiciliary beds: This ratio is to be 1:5.

(4) In CWT-TR programs: This ratio is to be 1:10.

NOTE: Where special circumstance warrant, medical centers may request a waiver from the staff to bed ratio. Written requests for waivers must be submitted to the Director, Residential Rehabilitation and Treatment Programs, OMHS, VA Central Office.

f. **Staff Training**

(1) All MH RRTP staff must be knowledgeable about women's health care needs and treatments, must participate in ongoing education about the care of women, and must be competent to provide gender-specific care to women.

(2) Suicide Risk Assessment must be included in the mandatory annual competency training for all members of the interdisciplinary clinical team in every MH RRTP (see subpar. 26e).

(3) Staff working in specialty MH RRTPs must possess training and competencies in accordance with the following guidelines:

(a) Training for staff working with SMI Veterans (see subpar. 29i).

(b) PRRTTP staff training (see subpar. 30e).

(c) SARRTP staff training (see subpar. 31f).

(d) PTSD-RRTP staff training (see subpar. 32j).

(e) CWT-TR staff training (see subpar. 34g), which includes required documentation for training of CWT-TR House Managers.

16. ADMISSION

a. Veterans may apply directly for MH RRTP services or be referred from other programs, both within and outside VHA. Since all admissions must be voluntary, Veterans under court-ordered treatment are appropriate for MH RRTP care, but a court's order cannot override a program's otherwise valid admission decision. VA cannot assume responsibility for custody nor guarantee LOS.

b. Veterans need to be screened for admission to MH RRTPs by staff members who are capable of assessing their medical and psychiatric stability and their suitability for admission to the program.

(1) All Veterans must receive a health care screening by a physician or qualified health care provider prior to admission. This screening determines medical appropriateness for the MH RRTP and indicates areas of ongoing treatment and potentially urgent medical needs. Screening must be offered on all normal business days.

(2) Each Domiciliary Chief or MH RRTP Program Manager is to develop specific policies, procedures, guidelines, and selection criteria that are consistent with the services offered by the MH RRTP and that minimize access barriers to the program.

(3) The Domiciliary Chief or MH RRTP Program Manager is responsible for local screening policies and admission decisions, but may delegate the process to appropriate staff members (see par. 17). **NOTE:** *All Veterans screened for admission for a MH RRTP must have workload documented in stop code 596 and in the Veteran's Computerized Patient Record System (CPRS).*

c. **Admission Criteria.** The Veteran must:

- (1) Be assessed as not meeting criteria for acute psychiatric or medical admission.
- (2) Have tried a less restrictive treatment alternative, or one was unavailable.
- (3) Be assessed as requiring the structure and support of a residential treatment environment.
- (4) Be assessed as not a significant risk of harm to self or others.
- (5) Be lacking a stable lifestyle or living arrangement that is conducive to recovery.
- (6) Be capable of self preservation and basic self care.
- (7) Have identified treatment and rehabilitation needs, which can be met by the program.

d. Veterans cannot be denied admission to MH RRTPs based solely upon length of current abstinence from alcohol or non-prescribed controlled substances, the number of previous treatment episodes, the time interval since the last residential admission, the use of prescribed controlled substances, or legal history. The screening process must consider each of these special circumstances and determine whether the program can meet the individual Veteran's needs while maintaining the program's safety, security, and integrity.

e. Veterans accepted for admission must be given a tentative admission date and a point-of-contact during the time period prior to admission (if any). Admission must occur in the most expeditious manner possible. The Admission Note must include a statement of the Veteran's strengths, abilities, needs, and preferences, in addition to the standard admission note content. A written order is required to admit the Veteran to MH RRTP. **NOTE:** *The provisions of VHA Handbook 1004.01 on informed consent apply to all MH RRTPs.*

f. As a general rule, Veterans are admitted to the program in the order in which they are screened or accepted. **NOTE:** *Exceptions may be made at the discretion of the MH RRTP Program Manager for clinical circumstances.*

g. MH RRTPs are not an appropriate level of care to provide acute medically-managed or medically-monitored detoxification to Veterans at moderate to severe risk of withdrawal. Veterans assessed as meeting the criteria for ambulatory withdrawal management consistent with the VA-Department of Defense (DOD) Clinical Practice Guidelines may be admitted to an MH RRTP as part of a plan to provide treatment and rehabilitation for SUD. These Veterans must meet the admission criteria for a MH RRTP and be willing to participate in on-going treatment and rehabilitation as part of the residential continuum of care. MH RRTP's are not used as short-term housing of Veterans needing ambulatory detoxification, unless it is integrated with clinically-indicated on-going residential treatment and rehabilitation.

h. If the Veteran's circumstance cannot be accommodated by the program, alternative services must be considered within the medical centers, VISNs, or VHA's mental health continuum of care and appropriate alternate treatment arrangements made.

NOTE: *MH RRTPs that develop additional admission criteria must contact Director, Residential Rehabilitation and Treatment Programs, OMHS, VA Central Office for concurrence.*

17. SCREENING

a. Veterans applying for MH RRTP admission generally face significant barriers to treatment access. Poverty, homelessness, disabilities, and other psychosocial circumstances are some of the co-occurring conditions that present significant challenges to entry into MH RRTP programs. Some Veterans are unable to secure transportation to screening appointments. After attending initial appointments, Veterans may additionally be asked to return for further evaluation by other MH RRTPs located at the facility. In the past, sequential screenings have delayed treatment and also increased the chance that a Veteran, who might otherwise benefit from services, was lost. MH RRTPs are required to take the following steps to reduce these barriers to treatment.

(1) A single screening determines whether a Veteran is appropriate for admission to any of the facility's MH RRTPs. To facilitate access, screenings are conducted on all normal business days. Given the co-morbid disorders typical of a Veteran being screened for residential services, consideration needs to be given to which MH RRTP provides the "best" fit, rather than the ideal match.

(2) The screening team needs to be composed of staff that has the necessary competence to make an admission decision for all of the facility's MH RRTPs. At a minimum, the screening team must include a licensed mental health professional and a licensed physician or a licensed physician extender.

(3) The Domiciliary Chief or MH RRTP Program Manager is responsible for facilitating access to screening by coordinating transportation assistance or through the use of technologies, such as video conferencing, or employing off-site or outreach staff to screen for admission. All Veterans referred for screenings must be asked if they need assistance to attend a screening. Their response must be noted in the Veteran's record. When the referral to the MH RRTP involves a transfer between facilities, the referring facility staff must maintain full responsibility

for the Veteran until the time of admission. It is the responsibility of staff at the referring facility to ensure transportation to the MH RRTP location for screening or admission.

(4) Veterans screened and accepted for MH RRTP admission must be provided information about the circumstances, expectations, and any limitations of the program to which they are to be admitted to ensure that they are fully aware of their responsibilities and any restrictions imposed by the program. This must occur in advance of admission to enable the Veteran to make an informed decision and to begin the process of a rehabilitation and recovery.

(a) Veterans not accepted for care must be provided information as to the reasons for non-acceptance, and these reasons must be appropriately documented in the Veteran's health care record.

(b) For Veterans who are not accepted, alternative sources of care must be explored and referrals made, as appropriate, to ensure that needed care is provided.

(5) The Veteran's strengths, needs, abilities, and interests must be explored during the screening process to begin the process of establishing a recovery plan.

b. **Drug and Alcohol Screening.** Residents are prohibited from using or possessing alcohol and non-prescribed drugs while residing in the MH RRTP.

(1) To ensure a substance-free environment, residents must agree to alcohol and drug screenings on a regular, random, or as-clinically-indicated basis as specified in their treatment plan. Abstinence monitoring needs to occur at least weekly in early treatment with frequency modified based on indications of relapse risk and should include testing for abuse and diversion of prescribed controlled medications. Residents are to be randomly tested upon return from passes.

(2) Monitoring procedures include observed sample collection in space specifically designed for this purpose or with other methods to ensure that samples are not adulterated (e.g., temperature strips) and promote rapid preliminary feedback (e.g., breathalyzer), with laboratory confirmation available for disputed results. Quantitative urine toxicology screening may be used in cases where an abused substance may remain in a resident's system for a number of days or weeks.

(3) Residents who do not adhere to this monitoring policy must have careful review of their appropriateness for residential care and may be subject to discharge from the residential program. If a resident is discharged continuing VA and non-VA services for medical, addictions, and other MH needs must be arranged.

18. HEALTH RECORD REQUIREMENTS

The MH RRTP record must be integrated into the CPRS as outlined in VHA Handbook 1907.01. Doctor's orders include, but are not limited to the: admission order, discharge order, medication order, significant medical or psychiatric conditions affecting patient care, referral or

consultation order, etc. Documentation standards for MH RRTPs must adhere to all accrediting body standards and VHA policies.

19. HISTORY AND PHYSICAL EXAMINATION (H&P)

a. A complete H&P examination by a physician or qualified health care provider is required. An interval H&P, reflecting any changes since the last exam, may be sufficient when deemed appropriate by professional judgment and in conformance with accrediting bodies such as TJC and CARF. Timeframes for completion of H&Ps (to include updates) need to be established based on current accreditation standards, but must be completed no more than 7 days after admission. A Veteran remaining on MH RRTP status for 1 year or longer, must be given an annual examination, to include mental status. The H&P must address any physical findings or medical problems that have an impact on the Veteran's current treatment. Veterans transferring from one MH RRTP to another within VA do not require a new H&P. The H&P examination must include, but is not limited to:

- (1) Any history of physical abuse or MST.
- (2) Infection and communicable diseases, specifically to include the tuberculin skin test or chest x-ray, as indicated.
- (3) Use of alcohol or other drugs (including the age of onset, duration, patterns, and consequences of use).
- (4) Response to any previous treatment.
- (5) Diagnostic testing, including invasive and non-invasive diagnostic testing and imaging.
- (6) Identification of psychiatric issues, which may require further assessment by the MH service.
- (7) Age and gender-appropriate preventive medical screening, such as mammograms, Papanicolaou (Pap) smears, and prostate screening.

b. Given the heightened risk for Hepatitis C among patients with SUD, Hepatitis C testing must be conducted on all Veterans in MH RRTP with an antibody test and confirmatory testing done for viremia if the Hepatitis C antibody is positive. More information on Hepatitis C can be found at <http://vaww.hepatitis.va.gov>. *NOTE: This is an internal VA web site not available to the public.*

c. Routine Human Immunodeficiency Virus (HIV) testing must be offered to all Veterans in MH RRTP. Voluntary, routine HIV screening is recommended for Veterans at least once and HIV testing must be offered at least annually for Veterans with on-going risk factors. Verbal consent is required prior to HIV testing, written information material regarding HIV must be provided to patients, and documentation of consent is required in the medical record (per VHA Handbook 1004.01). More information on HIV, including patient education materials can be

20. ASSESSMENT

a. All Veterans admitted to a MH RRTP must receive a thorough, comprehensive, interdisciplinary assessment. This assessment may be conducted in a variety of ways, but must include certain basic elements and address other factors as clinically indicated (see following subpars. 20b-20f). The results of the assessment must be integrated into a summary in the Veteran's health care record and must serve as the basis for creating the Veteran's treatment and recovery plan. Assessment is an individualized process that begins at the time of screening and continues until discharge. The assessment process is interdisciplinary and takes into account the Veteran's strengths, needs, abilities, and preferences for care, treatment, and services. Since assessment is an on-going process, each Veteran needs to be reassessed at appropriate intervals, or as warranted by the Veteran's condition and circumstances.

b. **Comprehensive Biopsychosocial Assessment.** A comprehensive biopsychosocial assessment must be documented within 5 working days of admission, to include an interpretive summary based on the assessment data. This assessment of current emotional and behavioral functioning must be completed within timeframes established by accrediting body standards. This assessment must include, but is not limited to:

- (1) Identifying information;
- (2) History of present illness, including emotional and behavioral functioning and maladaptive or problem behaviors;
- (3) Current emotional and behavioral functioning, including Traumatic Brain Injury (TBI) screening;
- (4) Environment and living situation;
- (5) Leisure and recreation;
- (6) Religious and spiritual orientation;
- (7) Personal and family psychiatric history;
- (8) Medical history impacting psychiatric history;
- (9) History of substance use, abuse, or addiction and any related treatment;
- (10) Social and developmental history, to include child abuse and neglect;
- (11) Military history and trauma screening;
- (12) Financial issues;

(13) Legal history and any current pending legal matters;

(14) Current social supports and stressors, including work, sexual history and orientation, next-of-kin, or significant others; and

(15) Any needed program specific assessments.

c. **Assessment for Occupational Dysfunction and Employment Services.** The assessment for occupational dysfunction and employment services must be completed as part of the biopsychosocial assessment with identified needs addressed in the rehabilitation plan (see par. 25). If Veteran is in need of additional vocational rehabilitation treatment, a referral to vocational rehabilitation and employment services must be completed as part of the initial rehabilitation plan.

d. **Suicide Assessment.** See paragraph 26.

e. **Nursing Assessment.** The nursing assessment needs to be done within 24 hours of admission.

NOTE: A nursing assessment is not required in the CWT-TR program. This assessment must include, but is not limited to:

(1) Height;

(2) Weight;

(3) Vital signs, including pain assessment;

(4) A functional assessment, including activities of daily living (ADLs);

(5) The potential risk for falls;

(6) The ability to self-administer medications, including any limitations, special circumstances, or individual requirements;

(7) An evaluation of high-risk behaviors; and

(8) Significant medical or psychiatric conditions affecting patient care.

f. **Additional Assessments.** Additional assessments are done as needed or as required by accreditation standards, such as a:

(1) Nutritional Assessment;

(2) Therapeutic Recreation Assessment; or

(3) Oral Health Assessment.

21. REHABILITATION OR TREATMENT PLAN

a. An individualized rehabilitation or treatment plan must include specific goals, measurable objectives, targeted dates for completion, and a designated responsible individual for addressing each goal.

(1) The treatment and recovery planning process is designed to assist each Veteran in identifying strengths, needs, abilities, and preferences and to incorporate those into the plan. This planning process is done in each MH RRTP by an interdisciplinary team of staff with the Veteran a full partner in the process.

(2) Timeframes for developing and updating plans are based on accrediting body standards. The Veteran's needs, problems, goals, and action plans are identified utilizing information obtained through the assessment process, including direct input from the Veteran and from the Veteran's family or significant others, as available and appropriate. VHA providers beyond the MH RRTP who are currently involved in the Veteran's care need to be included in the planning process whenever feasible.

b. Interdisciplinary treatment team meetings need to be conducted with the Veteran present, as appropriate. Specific target dates need to be identified and monitored. The interdisciplinary team conducts periodic reviews throughout the Veteran's stay, consistent with accrediting body standards. Reviews can also be requested by the Veteran, a team member, or another provider involved in the Veteran's care.

c. **Rehabilitation Progress Notes.** The frequency of recording progress notes must be established by the medical center in program policies, and be appropriate for both the Veteran populations served and the program objectives. Progress notes must reflect:

- (1) The Veteran's progress towards treatment plan goals and objectives;
- (2) Any barriers to progress and strategies employed; and
- (3) Any significant events and changes in status.

22. DISCHARGE

a. **Discharge Planning**

(1) Discharge planning for each Veteran starts at the time of admission. Discharge planning is for the Veteran to identify personal needs for continuing recovery, care, treatment, and services after discharge. Discharge planning is addressed at each interdisciplinary treatment team meeting with the Veteran. LOS is variable based on progress towards goals, objectives, and time frames listed in the rehabilitation plan. The timing of transition to the community is negotiated between the Veteran and the team. Staff are responsible for ensuring that access barriers to continuing outpatient care (e.g., distance, transportation, scheduling) are reduced or eliminated.

(2) There are circumstances when the interdisciplinary team may take unilateral action to discharge a Veteran prior to program completion. These circumstances include:

- (a) Dangerous behavior;
- (b) A relapse or unauthorized use of an addictive substance; and
- (c) A pattern of “lack of engagement” in treatment services.

(3) Whether the Veteran has completed the program or discharge is initiated due to unacceptable conduct, the same approach to discharge planning occurs.

- (a) The Veteran is involved in the discharge planning process.
- (b) The Veteran is provided clear information regarding discharge.

(c) Continuity of VA and non-VA services for medical, addictions, and other MH needs are arranged. This includes decisions regarding the setting and frequency of ongoing treatment and community recovery activities.

(d) Designated MH RRTP staff follow-up with the Veteran post-discharge to facilitate access to continuing aftercare services.

(e) An assessment of dangerousness and overall MH stability is made and appropriate action taken, if needed.

(f) If the Veteran does not have permanent housing, the treatment team provides information that facilitates arrangements for transitional or temporary housing.

(g) The treatment team provides the Veteran with a copy of the Veteran’s current medication list, the name and contact number of the primary care provider, a list of pending appointments, and all other information in support of the on-going treatment of medical, addiction, and mental health issues.

(h) The treatment team notes in the medical record the Veteran’s contact information following discharge.

(i) As appropriate, other providers such as OEF and OIF outreach workers, Recovery Coordinator, Suicide Prevention Coordinator, Women Veterans Coordinator, addiction staff, the Mental Health Intensive Case Management (MHICM) Team, PRRC staff, community providers, and telemental health clinicians are contacted, and the Veteran linked to their services.

(4) If a Veteran refuses to participate in discharge planning or if a Veteran drops out of treatment without seeing or contacting staff, a member of the treatment team enters a discharge note with as much of the preceding information as possible (see subpar. 22a(3)). In addition, that staff member addresses, based upon the last known information, whether the Veteran may be at significant risk of harm to self or others. Designated MH RRTP staff contact the Veteran for

follow-up. If the Veteran appears at risk, the Domiciliary Chief or MH RRTP Program Manager, local MH leadership, and the VA police are contacted for follow-up.

(5) The criteria for discharge generally depend upon the following:

(a) The Veteran has accomplished the goals as defined in treatment and recovery plan and is prepared for community re-entry with identified resources for after discharge.

(b) The Veteran requires treatment beyond program resources and is to transition to another level of care.

(c) The Veteran has failed to adhere to the rules and the regulations of the program.

(d) The treatment environment does not meet the Veteran's expectations.

(e) The Veteran requests to leave before treatment goals are met.

(f) The Veteran has a personal emergency necessitating discharge.

b. **Discharge Summary.** The discharge summary, signed by a physician or appropriately credentialed health care provider, must be consistent with VHA Handbook 1907.01, the external accreditation standards, and facility by-laws. A copy of the discharge summary is sent to the Veteran's primary care provider. At the time of discharge from the MH RRTP, the designated MH RRTP provider must complete a discharge summary and the Veteran's treatment team must prepare a discharge note that includes the following:

(1) The reason for admission;

(2) A summary of treatment and recovery goals;

(3) The status of goals at discharge;

(4) The reason for discharge;

(5) All continuing care plans;

(6) Any pending appointments;

(7) The type of housing at discharge;

(8) Employment at discharge;

(9) Any education or training at discharge; and

(10) The income and income source at discharge.

23. RESIDENTIAL COSTS AND WORKLOAD CAPTURE

Veterans in MH RRTP programs may not be charged residential costs, such as lease expenses, utilities, maintenance, meals, etc., except within the CWT-TR Program.

a. **Residential Inpatient Costs.** Services provided to Veterans by staff assigned to, and in support of, the MH RRTP residential unit are captured as “bed days of care” under the following Treating Specialty Codes:

MH RRTP Type	Treating Specialty Code	DSS MPCR ID #
PRRTP	1K	1711
PTSD-RRTP	1L	1712
SARRTP	1M	1713
DCHV	37	1513
General CWT-TR	39	1717
General Domiciliary	85	1510
Domiciliary Substance Abuse	86	1511
Domiciliary PTSD	88	1512

NOTE: These services include, but are not limited to: admission, intake, orientation, rehabilitation plan development, case reviews, case management, therapeutic group, and individual counseling associated with the residential component, meals, dietetics staff, evening staff coverage, etc.

b. **Outpatient Costs**

(1) Services provided to MH RRTP Veterans by staff in established outpatient clinics (such as Outpatient SA Clinics, Day Treatment programs, PTSD Clinical Team (PCT), Vocational Rehabilitation Therapy, CWT, etc.) are captured as “outpatient visits.” These costs are, therefore, captured under the appropriate outpatient stop code for the specific clinic providing services.

(2) Services provided by residential staff to an outpatient, such as: screening, aftercare, telephone contacts, etc., must be captured under the following MH RRTP Stop Codes:

Decision Support Service (DSS) Identification (ID) NUMBER	Primary (P) Secondary (S) or Either (E)	DSS ID NAME
588	E	RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) AFTERCARE – INDIVIDUAL
593	E	RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) OUTREACH SERVICES
595	E	RESIDENTIAL REHABILITATION TREATMENT PROGRAMS (RRTP) AFTERCARE – GROUP

Decision Support Service (DSS) Identification (ID) NUMBER	Primary (P) Secondary (S) or Either (E)	DSS ID NAME
596	E	RESIDENTIAL REHABILITATION TREATMENT PROGRAMS (RRTP) ADMISSION SCREENING SERVICES
597	P	TELEPHONE/RESIDENTIAL REHABILITATION TREATMENT PROGRAMS (RRTP)
598	E	RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) PRE-ADMISSION - INDIVIDUAL
599	E	RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) PRE-ADMISSION - GROUP
599	E	RESIDENTIAL REHABILITATION TREATMENT PROGRAM (RRTP) PRE-ADMISSION - GROUP

24. ENVIRONMENT OF CARE

a. The facility Director must:

(1) Maintain compliance with VA and accrediting bodies' environment of care standards, including, but not limited to:

- (a) Life Safety Codes (LSC), space criteria, safety, security, privacy, and
- (b) Emergency planning and preparedness.

(2) Ensure that the environment is maintained in a clean and appropriately-furnished condition with timely repairs and regular maintenance.

(3) Ensure that each MH RRTP (except CWT-TR), secures all entrance and egress doors to the unit and maintains a single point of access utilizing keyless entry and Closed Circuit TV (CCTV) monitoring. All other entrance and egress doors must be alarmed (to alert staff to an emergency or unauthorized opening) and monitored by CCTV. **NOTE:** *Larger MH RRTPs with multiple residential programming areas may provide more than one entrance and egress access point.* MH RRTP staff may open the main entrance to the unit during normal business hours, as long as adequate staff are present on the unit to ensure that only authorized patients, staff, and visitors access the unit.

(4) Utilize CCTV with recording capability for access points and public areas. Public areas include access points, hallways, and stairwells. **NOTE:** *Public areas, such as common living areas should generally not be monitored by CCTV, although exceptions may be made if other methods of ensuring safety (e.g., rounds, placement of a staff station) are not practical due to the layout of the facility.*

(a) CCTV may not be installed in areas where treatment or other clinical activities are conducted or in private spaces, such as bedrooms and bathrooms.

(b) Programs must display signage alerting Veterans and visitors that they are being recorded.

(c) Veterans must be oriented at admission to the purpose of the CCTV and that the cameras are not monitored 24 hours a day.

(5) Ensure that all MH RRTPs have locking bedrooms and bathrooms for female Veterans.

(6) Ensure the environment is designed to promote an individual sense of well-being, optimism, and integration with the surrounding community (as opposed to a hospital- or dormitory-like dwelling). **NOTE:** *In the design and decoration of the space, a priority needs to be placed on promoting a sense of hope and belief in recovery.*

b. MH RRTP staff must conduct:

(1) At least one formal safety, security, and privacy self inspection each month that documents observations and corrective actions taken (including work orders submitted).

(2) Regular and random health and welfare inspections of both public areas and resident rooms to detect contraband and unsecured medications.

(a) Inspections of all residents' rooms must occur daily to detect unsecured medications.

(b) A minimum of 10 percent of resident rooms, lockers, and drawers must be inspected each week to detect contraband.

(3) Rounds (excluding CWT-TR) to ensure the safety and security of Veterans, staff, and visitors. Staff must conduct rounds every 2 hours of all public spaces, such as hallways, dayrooms, group rooms, stairwells, community bathrooms, etc., and document the findings.

(4) Beds check at approximately 11 p.m. and 6 a.m. These checks must coincide with the local daily procedures used to verify the physical presence of each resident. Based on a local assessment of high-risk behaviors or illness, staff may conduct increased checks on individual Veterans. These checks may take place on any shift, including night time bedroom checks. **NOTE:** *In CWT-TR Program the House Manager may conduct bed checks.*

(5) Health and welfare inspections of the Veteran's belongings at admission and random inspection of the Veteran's belongings upon return from pass.

c. The Domiciliary Chief or MH RRTP Program Manager must develop written procedures for detecting contraband brought on the unit.

25. VOCATIONAL REHABILITATION AND EMPLOYMENT SERVICES

a. Vocational rehabilitation and employment services are essential in meeting the psychosocial needs of Veterans with occupational dysfunctions. Each Domiciliary Chief or MH RRTP Program Manager must establish a plan for the provision of vocational rehabilitation and

employment services based on the Veteran's individual needs. Participation in vocational rehabilitation and employment activities needs to take place at the earliest appropriate point in the residential rehabilitation process. However, some Veterans may need to complete initial treatment programs for SUD or PTSD prior to beginning vocational activities. MH RRTP programs engage with the facility CWT program to ensure the highest level of participation in treatment planning for RRTP residents by vocational rehabilitation program staff is achieved. To the greatest extent possible, vocational rehabilitation program staff will participate in MH RRTP treatment planning and team meetings, to:

(1) Provide direct feedback regarding the Veterans' progress towards their vocational goals, and

(2) To assist in making adjustments in therapy to overcome barriers.

b. When occupational dysfunction or employment services are indicated in the biopsychosocial assessment a Vocational Assessment must be completed within 5 days of referral and integrated into the MH RRTP rehabilitation plan.

c. Each Domiciliary Chief or MH RRTP Program Manager must ensure coordination and integration of vocational assistance, IT, or CWT with residential services. If the vocational assessment determines that the Veteran's rehabilitation goals would best be served by an outcome other than community employment, the MH RRTP treatment team must provide the Veteran with information and assistance in accessing volunteer work or other regular activity that is meaningful to the Veteran.

26. SUICIDE RISK ASSESSMENT AND PREVENTION

a. All Veterans screened for admission to a MH RRTP must be assessed for suicide risk utilizing current VHA guidelines. In addition, upon admission to a MH RRTP all Veterans must be screened again for suicide risk utilizing the current VHA guidelines.

b. If the Veteran is deemed to be at risk due to the presence of warning signs, immediate measures must be taken to ensure the Veteran's safety.

(1) The Veteran must be referred for assessment by a licensed independent practitioner (LIP) at the local facility. This assessment must include a determination whether to admit the Veteran to a higher level of patient care.

(2) The Veteran must remain in the presence of a VHA staff member until that higher level of assessment takes place.

(3) The Suicide Prevention Coordinator at each facility must be contacted for any Veteran at risk.

(4) If the LIP determines that the Veteran can safely be admitted to the MH RRTP, then communication about that assessment must be shared immediately with the MH RRTP

interdisciplinary team and a plan must be made to help and support the Veteran through the crisis, to include enlisting the commitment of the Veteran and any appropriate family or friends.

c. All Veterans must be educated on how to call for help if they feel suicidal.

d. The assessment of hopelessness, depression, and suicidal thoughts, plan, ideation, or intention needs to be on-going throughout the course of care including:

(1) At the time of screening and again at admission to the program;

(2) At the time of treatment plan reviews;

(3) Prior to discharge from the program; and

(4) At any other time there is a particular concern (such as undergoing medication changes, provider changes, trauma, loss, and other major changes in living).

e. Suicide Risk Assessment must be included in the mandatory annual competency assessment for all members of the interdisciplinary clinical team in every MH RRTP. Staff members must know how to refer Veterans and get immediate assistance from other mental health providers. Refresher training is required if a staff member does not meet this competency. MH RRTP staff coordinate the program's suicide prevention procedures with the facilities Suicide Prevention Coordinator.

27. MEDICATION MANAGEMENT

a. VHA has shifted health care delivery from traditional inpatient hospital-based approaches to a range of residential and community-based delivery systems. This shift has fostered a greater emphasis on rehabilitative approaches that promote Veteran education and skill development designed for improved self-care. With these newer approaches to health care, Veterans are able to learn and practice self-care skills, including safe self-management of their medication regimens.

b. Veterans in MH RRTPs are able to learn and practice self-management of their medication regimens in order to achieve independent medication administration. A local policy for Safe Medication Management (SMM) must be developed within the unit. **NOTE:** *The SMM is based on the medication management policies and procedures outlined in Appendix C.*

28. ACCESS AND SERVICES FOR WOMEN VETERANS

a. **Mental Health.** MH services must be provided to women Veterans at a level on par with male Veterans at each facility. All MH RRTP providers and staff must possess training and competencies to meet the unique mental health needs of women Veterans. Women Veteran capacity must be, at a minimum, equivalent to the current proportion of the women Veteran utilization rates or the specific VISN utilization rate for that site, whichever is greater. **NOTE:** *Plans for new residential programs must project a 15 percent minimum utilization rate for women Veterans.*

(1) Special attention needs to be given to meeting the unique needs of women Veterans, especially in the areas of SMI, sexual trauma, homelessness, eating disorders, and interpersonal violence.

(2) Each Domiciliary Chief or MH RRTP Program Manager ensures that gender-specific treatment and rehabilitation services are provided where appropriate.

(3) Women Veterans must have access (5 days a week) to a female clinician for additional individual treatment as needed. The female clinician must possess training and competencies to meet the unique mental health needs of women Veterans.

(4) Domiciliary Chief or MH RRTP Program Manager and staff are responsible for addressing gender issues to ensure safety and security within mixed gender groups.

(5) Empirically-supported interventions that have been proven effective with women need to be provided in SUD, combat-related trauma, MST, and PTSD therapeutic groups.

(6) MST counseling must be available to all Veterans who need residential treatment.

(7) Adjunct treatments such as weight management, fitness, recreation, and nutrition counseling need to be gender specific. Women Veterans need to have the option to have adjunct treatments separate from male Veterans.

b. **Environment of Care.** MH RRTPs maintain and adjust environments to support women Veterans' dignity, respect, and safety. Physical and psychosocial privacy must be provided to women Veterans. The Annual Safety and Security Assessment is conducted jointly with the Women Veterans Program Manager (WVPM). **NOTE:** *The WVPM should participate in regular environmental rounds with special emphasis on improving privacy and security.* MH RRTPs must provide:

(1) Separate and secure sleeping arrangements (unit or wing) for women Veterans.

(2) Safe and secure sleeping and bathroom arrangements. In mixed gender units, this includes but is not limited to, proximity to staff and door locks.

(3) Appropriate private space for women Veterans to visit with significant others and children at designated times.

(4) Gender-specific personal care and hygiene products.

c. **Complete H & P**

(1) The MH RRTP staff must contact the facility WVPM at the time of the woman Veteran's admission to assist in coordinating the physical examination and ensuring that the medical needs of women Veterans are met. MH RRTPs ensure coordination and integration with women's primary care clinics or teams, which are the optimal milieu for providing physical care to women

Veterans. The MH RRTP medical staff can be utilized in settings where there is no access to women's primary care clinics or teams. MH RRTPs must take into consideration the women's need for privacy, sensitivity, safety, and emotional and physical comfort.

(2) A complete H & P examination for women includes:

(a) Pelvic Examination. A pelvic examination is performed, unless medically contraindicated or refused by the patient.

(b) Breast Examination. Breast screening services offered include: clinical breast examination, education on performing breast self-examination, and mammography.

(c) A Pap Smear. Pap smears are offered according to accepted screening standards.

(d) Basic Gender-specific Care. Treatment of menopause, uncomplicated vulvovaginitis, osteoporosis, contraceptive needs, pregnancy evaluation and evaluation of desire for pregnancy, and hormone replacement therapy must be provided by the primary care provider or team.

(3) **Registries.** Women Veterans need to be encouraged to enroll in Depleted Uranium, Gulf War OIF, Ionizing Radiation, and Agent Orange environmental agents registries, when indicated.

29. ACCESS AND SERVICES FOR VETERANS WITH SMI

a. The Mental Health Strategic Initiative has called for mental health services, including MH RRTPs, to be recovery oriented. Recovery services are person-centered (versus program-centered), focused on functioning and community participation (versus symptoms), and strengths based (a growth model versus a maintenance model). All work is collaborative with the Veteran having control of the plan and goals. Recovery services include ten fundamental components: self-direction, individualized and person-centered, empowerment, holistic, non-linear, strengths-based, peer support, respect, responsibility, and hope. Recovery-oriented services for Veterans with SMI must be implemented in all MH RRTPs.

b. Background

(1) Persons with SMI recover at high rates. MH professionals need to approach such clients with an energetic commitment to rehabilitation and recovery with respect for the rich possibilities for a life with minimal to moderate impairment.

(2) Barriers to the inclusion of Veterans with SMI into residential programs need to be identified before they can be addressed. Existing barriers include:

(a) A lack of programming for Veterans with SMI.

(b) Staff and peer fears, including the stigma of SMI

(c) Access to medication management that meets the individualized Veteran's needs.

- (d) Suicidal or homicidal ideation.
- (e) A culture that is confrontational and punitive.
- (f) Low staff or community expectations for Veterans with SMI.

c. **Level of Care.** The level of care provided within all residential programs needs to be such that it does not preclude Veterans with special needs from admittance or participation. This includes assistance with medications. The requirement for self-medication has been noted to be one of the barriers that have precluded Veterans with SMI from participating in residential programs. Facilities with significant numbers of Veterans with SMI may find that there is sufficient need to justify creating a residential rehabilitation program that is dedicated to recovery for these Veterans.

d. **Referrals.** When a Veteran is referred to a residential treatment program both the Veteran and the referring source must have an opportunity to review the decision. The Veteran is to be given a written statement of what specific barriers need to be addressed, so that an admission can occur.

e. **Target Population.** The target population refers to Veterans with SMI, including those who have a co-occurring SUD (dual diagnosis).

f. **Admission Criteria.** Veterans with SMI who have active symptoms are not to be precluded from the opportunity to participate in residential treatment. Coping skills for living with these symptoms need to be a component of the programming, and need to include cognitive behavioral therapy, which teaches skills for challenging beliefs about symptoms.

g. **Specialized Care and Treatment Modalities**

(1) Recovery is collaborative, respectful, person-centered, and strengths based. Evidence-based psychosocial rehabilitation practices and treatments include:

- (a) Basic behavioral principles of noticing and reinforcing positive behaviors and progress (strengths based and hope building);
- (b) A culture of trust and engagement (active listening skills, motivational interviewing, and enhancement);
- (c) Treatment modalities that include social skills training;
- (d) Cognitive behavioral skills for coping with psychosis, paranoia, and bipolar disorder;
- (e) Behavioral tailoring for medications;
- (f) Family psycho-education;
- (g) Intensive case management; and

(h) Relapse prevention, such as supported employment, supported housing, and illness management and recovery.

(2) Dialectical behavior treatment skills (including distress tolerance and emotion regulation) can also be offered to further help Veterans with self regulation and recovery.

(3) The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends that practitioners regularly use the following skills in their interactions and practice with Veterans who have SMI:

(a) Cognitive-behavioral techniques, such as positive reinforcement, shaping, modeling, role playing, cognitive restructuring, and relaxation training;

(b) Motivational strategies (e.g., exploring pros and cons of change);

(c) Educational techniques;

(d) Behavioral tailoring for medication(s) (e.g., tailoring strategies to each individual's needs and resources); and

(e) Relapse prevention training.

h. **Integrated Dual Diagnosis Treatment.** The components of an integrated dual diagnosis treatment program include:

(1) A multidisciplinary team, with an integrated SA specialist;

(2) Stage-wise interventions;

(3) Access for Veterans to comprehensive dual diagnosis services;

(4) Time-unlimited services;

(5) Outreach (for recruitment, engagement, and re-engagement);

(6) Motivational interventions;

(7) SA counseling;

(8) Group dual diagnosis treatment;

(9) Family psycho-education on dual diagnosis;

(10) Participation in alcohol and drug self-help groups;

(11) Pharmacological treatment;

(12) Interventions to promote health; and

(13) Secondary interventions for SA treatment non-responders.

i. **Staffing Guidelines.** Staffing needs to be adequate to ensure that the support and skills necessary for work in recovery and inclusion of persons with SMI is possible. This includes: identifying a process for staff to manage medications, persons familiar and trained in integrated dual diagnosis treatment, and persons trained in recovery practices. Programming and staffing needs to be sufficient to ensure that Veterans with SMI can advance their self-medication status. This may entail use of education either inside the residential facility or from outside sources, such as PRRC, outpatient MH Clinic, or primary care.

j. **Quality of Care.** Quality of care needs to meet the SAMHSA guidelines of Illness Management and Recovery and the United States Psychiatric Rehabilitation Association. This includes care that is: person-centered, collaborative, strengths-based, and focused on functioning and achievement of recovery goals.

k. **Environment of Care.** Veterans with SMI, and other mental disorders, do not respond to a confrontational or coercive environment. SAMHSA's Illness Management and Recovery guidelines recommend that the focus of treatment be on strengths and that staff use behavioral reinforcement in each group or session. In addition, the guidelines call for the use of motivational enhancement and cognitive strategies to help persons set and achieve their personal goals. This shifts the culture to a strengths-based one of support and collaboration.

(1) In recovery from SMI, the focus is on supportive risk taking and building hope and belief in recovery. Criticism, confrontation, punishment, or punitive tasks do not further recovery and may discourage persons who have experienced trauma, paranoia, and other SMI from entering or completing the program. Staff need to be trained in other methods that: promote recovery in order to increase their confidence in working with Veterans with SMI, reduce the stigma towards mental illness, and help move programs towards the Mental Health Strategic Initiative of recovery-based services.

(2) The physical environment needs to be designed to promote an individual sense of well-being, optimism, and integration with the surrounding community (as opposed to a hospital- or dormitory-like dwelling). In the design and decoration of the space, a priority needs to be placed on promoting a sense of hope and belief in recovery.

30. PSYCHOSOCIAL RESIDENTIAL REHABILITATION TREATMENT PROGRAM (PRRTP)

a. **Description.** A PRRTP may be a stand alone program or may be designated beds within a DRRTP (i.e., General Domiciliary Beds). This is designed to provide a stable supervised recovery environment for the treatment and rehabilitation of those Veterans who need such a setting because of the complexity of their condition. The following factors, in combination, impinge on the Veteran's community functioning and access to treatment, and limit the potential effectiveness of ambulatory treatment:

- (1) A combination of the Veteran’s medical, mental illness, or addiction severity;
- (2) Significant biopsychosocial co-morbidity, including homelessness; and
- (3) Serious relapse potential at less intensive levels of care, or at least moderately high-risk recovery environment (e.g., lack of safe and sober living setting).

b. **Structure and Level of Care.** PRRTPs are highly flexible in design and may serve a variety of Veteran populations. PRRTP’s range from highly structured and staffed “all inclusive” units serving the complex needs of Veterans with SMI, to health maintenance beds within a DRRTP, or to less structured and staffed “supportive residential” programs serving Veterans psychosocial and recovery needs.

c. **Target Population.** PRRTPs are a “general” beds category and as such, may serve any Veteran population assessed as eligible for MH RRTP services who meet the admission criteria of the program. Target populations include, but are not limited to Veterans with medical, mental illness, addiction, and psychosocial deficits, including homelessness. The PRRTP bed section is not to be used exclusively for the treatment of Veterans with SUD, exclusively for the treatment of Veterans with PTSD, or exclusively for the treatment of Veterans with homelessness as the primary admission diagnosis. In these cases, the appropriate specialty bed section must be used instead.

d. **Referrals.** Veterans may apply directly for PRRTP admission or be referred from other programs, both within and outside of VHA. For Veterans referred from other VHA programs, decisions about admission need to be made jointly by PRRTP and referring staff. Known or suspected medical problems that require care must be identified in the referral. Referral procedures must facilitate access to care and promote timely involvement in the rehabilitation process.

e. **Staffing Guidelines.** In addition to the MH RRTP core staffing, PRRTP specialty staffing size and level of staff training is dependent on the program structure (all inclusive versus supportive residential), bed capacity, and the specialized needs of the Veterans being served. A more highly-structured setting with VA staff capable of providing appropriate care and guidance is necessary for Veterans who have recently detoxified, or who have poor or underdeveloped community living skills, or who have a history of significant maladaptive social behavior. Alternatively, Veterans who are in the final stages of a long-term residential treatment focused on community re-entry may require less direct staff supervision and structure.

31. SUBSTANCE ABUSE RESIDENTIAL REHABILITATION TREATMENT PROGRAM (SARRTP)

a. **Description and Target Population.** SARRTPs are designed to provide a stable drug and alcohol-free supervised recovery environment for the treatment and rehabilitation of those Veterans with SUD who need such a setting because of the complexity of their condition. Complexity may be due to a combination of the Veteran’s addiction severity, significant biopsychosocial co-morbidity, and serious relapse potential at less intensive levels of care, or at

least moderately high-risk recovery environment (e.g., lack of safe and sober living setting). These factors in combination impinge on the Veteran's community functioning and access to treatment, and limit the potential effectiveness of ambulatory treatment.

b. **Structure and Level of Care.** SAR RTP care is guided by the evidence-based VA-DOD Clinical Practice Guideline for the Management of Patients with SUD. Consistent with the Guideline, care in SAR RTPs must include access to evidence-based psychosocial interventions, as well as addiction-focused pharmacotherapy for opioid or alcohol dependence, when indicated. The VA-DOD Guideline recommends use of the most recent Patient Placement Criteria of the American Society of Addiction Medicine that define residential levels of care, admission criteria, staffing models, assessment dimensions, intensity, focus of treatment services, and treatment review guidelines.

c. **Referrals.** Veterans may apply directly for SAR RTP admission or be referred from other programs, both within and outside of VHA. For Veterans referred from other VHA programs, decisions about admission need to be made jointly by SAR RTP and referring staff.

d. **Admission Criteria.** In addition to general criteria addressed in paragraph 16, admission to SAR RTP needs to be consistent with the level of care designated (i.e., assessment for risk of no more than mild withdrawal using the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) or other standardized procedures, or no need for continuous monitoring), the SAR RTP service model (all-inclusive versus supportive residential with adjunctive services available from ambulatory care providers), and must not exclude patients based on length of sobriety or clinically-indicated treatment (e.g., prescribed controlled substances). Timely access to care is an important aspect of treatment engagement for patients in need of SAR RTP. Patients need to be informed promptly and updated frequently about their admission status; services need to be provided or arranged in the community during any interim from referral to admission.

e. **Discharge Planning and Continuity of Care.** During the residential stay, SAR RTP's need to systematically promote:

(1) Access to self help groups both on-site and in the community; and

(2) Active involvement through evidence-based approaches, such as 12-Step Facilitation and other support groups.

f. **Staffing.** In addition to the MH RRTP core staffing, SAR RTP specialty staffing size and level of staff training is dependent on the bed capacity and the specialized needs of the Veterans being served.

(1) For example, Veterans who have recently detoxified, who have poor or underdeveloped community living skills, or who have a history of significant maladaptive social behavior require a more highly-structured setting by VA staff capable of providing appropriate care and guidance.

(2) Alternatively, Veterans who are in the final stages of a long-term residential treatment focused on community re-entry may require less direct staff supervision and structure. In an "all

inclusive” program, the staff needs to include a minimum of at least two FTE LIPs (e.g., Masters of Social Work social worker, Ph.D psychologist) with credentialing and privileging or documented competencies in delivery of evidence-based psychosocial interventions for SUD. Dedicated FTE must also be accessible within the SAR RTP staff or through other programs, to provide addiction-focused pharmacotherapy.

(3) In a “supportive residential” program, service from LIPs are generally part of the outpatient addiction treatment program, but at least the Domiciliary Chief or MH RRTP Program Manager and one additional FTE staff member need to have documented competencies in treatment of SUD.

(4) In all cases, licensed professional program staff must be available to serve the SAR RTP Veterans at all times on a scheduled and on-call basis.

(5) Non-licensed staff members who have direct clinical or administrative supervision duties for Veterans within the SAR RTP, must be trained to:

(a) Provide appropriate management of the therapeutic milieu;

(b) Make and document accurate observations of the Veteran’s behavior; and

(c) Provide appropriate prompting and guidance to Veterans in the completion of the therapeutic assignments or in the use of skills being taught as part of the SUD treatment or residential rehabilitation.

32. POST-TRAUMATIC STRESS DISORDER RESIDENTIAL REHABILITATION TREATMENT PROGRAM (PTSD-RRTP)

a. **Description.** The PTSD-RRTP provides a safe, supportive, and structured residential rehabilitation environment for Veterans who are actively involved in treatment for PTSD and any existing co-occurring disorders.

(1) Veterans may require residential rehabilitation based on factors such as: severity of illness, high-relapse potential, exacerbation of co-occurring disorders, and absence of a safe, supportive recovery environment.

(2) Services include, but are not limited to: continuing PTSD treatment, SUD treatment (if applicable), residential rehabilitation, and psychosocial rehabilitation, including employment, community supports, and housing. **NOTE:** *The unique environmental and treatment needs of women Veterans must be addressed.*

b. **Structure and Level of Care.** PTSD-RRTP care is provided in a therapeutic community, recognizing that Veterans served are in need of a time-limited, supportive, safe environment while pursuing an individualized program of recovery. Since independence, self-determination, and self-management are core principles of care, the program structure must facilitate implementation of these principles.

c. **Target Population.** Veterans who meet the diagnostic criteria for PTSD or have a significant trauma-related readjustment problem are eligible for admission to the PTSD-RRTP. If a Veteran has a co-morbid mental health diagnosis (e.g., SUD), both disorders must be sufficiently under control to allow effective participation in both the treatment and residential rehabilitation services.

d. **Referrals.** Referrals must include the diagnosis of PTSD or must document the existence of a trauma-related readjustment problem. Known or suspected medical problems that require care must also be identified in the referral. Referral procedures must facilitate access to care and promote timely involvement in the rehabilitation process.

e. **Admission Criteria.** PTSD-RRTP care is designed to facilitate and encourage access. Simplicity in referral and application for care is emphasized.

(1) Admission criteria are minimal and generally only require the presence of PTSD or a trauma-related adjustment problem, willingness by the Veteran to engage in PTSD-RRTP services, and the ability to function within the PTSD-RRTP level of care.

(2) Denials for admission must: document the reasons for denial; provide methods for the applicant to submit a successful application for care when possible; and ensure alternate, appropriate care options are provided to the Veteran.

f. **Specialized Care and Treatment Modalities.** Treatment in the PTSD-RRTP is only one episode of care within a much more extensive recovery process. PTSD-RRTP staff actively engage community resources and help the Veteran plan for continued recovery and aftercare.

g. **Assessment and Recovery Needs.** While there are common core needs among Veterans with PTSD, individual recovery needs may vary widely.

(1) A biopsychosocial assessment procedure that addresses these potential needs is essential in planning care with the Veteran. Homelessness, co-occurring disorders, family involvement, and employment issues are often significant challenges to Veterans in the PTSD-RRTP. Evidence demonstrates that access to family psycho-educational services and supported employment significantly improves outcomes.

(2) A comprehensive psychosocial assessment is vital to the development of a comprehensive rehabilitation and recovery plan (see par. 20).

h. **Treatment and Rehabilitation.** Services may occur within the PTSD-RRTP or through participation in outpatient clinics. Treatments for PTSD include traditional evidence-based practices described in the joint VA-DOD PTSD Clinical Practice Guidelines.

(1) While group treatment is a common delivery format for a variety of services, the provision of individualized services using evidence-based trauma processing treatments (e.g., Prolonged Exposure, Cognitive Processing Therapy (CPT), and other evidence-based treatments) is recommended. Treatment for co-morbid disorders occurs on a concurrent basis, whenever

possible or appropriate, either through staff embedded in the PTSD-RRTP or through care from a specialized substance abuse program.

(2) A recovery orientation in rehabilitation is integral to the PTSD-RRTP. Programs must engage the Veteran in peer support while enrolled in the program and encourage the extension of peer support to outpatient care following discharge. Emphasis is placed on full partnerships between the staff and Veterans in developing plans of care. Veteran self-determination is strongly emphasized and normalized community integration is the goal of services.

i. **Evidenced Based Practices.** Programs must offer access to evidence-based practices for PTSD treatment, such as CPT and Prolonged Exposure Therapy. Appropriate assessments for PTSD and related disorders need to be utilized to facilitate admission and, once discharged, to monitor program efficacy. Resources must be made available for high-frequency medical comorbidities, such as: hypertension, diabetes, methadone maintenance, and HIV. Access to expertise in recognizing and treating MST and TBI is also required. Family psycho-education and supported employment, also evidence-based practices, must be available in the PTSD-RRTP range of services.

j. **Staffing Guidelines.** Staffing of the PTSD-RRTP is appropriate to the goals and mission of the program and is consistent with requirements described in local facility policy and in expectations of accrediting agencies. PTSD-RRTP services require capacity in differential diagnosis, recovery planning, psychosocial rehabilitation, evidence-based practices in PTSD treatment, and evidence-based practices in psychosocial rehabilitation, including family psycho-education, supported employment, and care for co-occurring disorders. Capacity for medical evaluation and discharge planning is required. Consequently, access to staff that is competent to provide these services is essential. These services may be provided by staff on the PTSD-RRTP (all inclusive model) or by staff in an outpatient PTSD program (supported model).

33. DOMICILIARY CARE FOR HOMELESS VETERANS (DCHV)

a. Congress has recognized a need to care for homeless Veterans and to ameliorate the causes of their homelessness (Public Law 100-71). All MH RRTP models are considered appropriate for the provision of care to homeless Veterans. Domiciliary eligibility requirements are outlined in 38 U.S.C. 1710 and further outlined in 38 CFR 17.46 and 17.47.

b. **Description.** The DCHV Program was implemented in 1987, following passage of Public Laws 100-71 and 100-6, to address the complex clinical needs of the large number of homeless Veterans. DCHV provides time-limited residential treatment to homeless Veterans with significant health care and social-vocational deficits. DCHV provides homeless Veterans access to medical, psychiatric, and SA treatment in addition to social and vocational rehabilitation including access to IT, CWT, and Supported Employment (SE) Program. The goals of DCHV are to:

(1) Address the co-occurring disorders and complex psychosocial barriers contributing to homelessness;

(2) Improve the health status, employment performance, and access to basic social and material resources among Veterans;

(3) Reduce overall reliance on VA inpatient services; and

(4) Prepare Veterans for, and place them in, a safe, community environment.

c. **Structure or Level of Care.** DCHV provides comprehensive biopsychosocial rehabilitation, including attention to the broadest possible range of Veteran needs (e.g., medical, psychiatric, social, vocational, and spiritual) through direct provision of care or by integration with MH, SA, primary care, and other MH RRTPs. This program provides time-limited residential care in a Domiciliary setting designed to maximize each Veteran's potential for return to independent or supported community living. DCHV residents meet the criteria for domiciliary level of care. Individual DCHV programs may be part of larger Domiciliary or stand alone programs.

d. **Target Population.** The DCHV Program serves homeless Veterans, or Veterans at risk for homelessness, who have a clinical need for psychosocial residential rehabilitation services. An emphasis must be placed on providing treatment to currently homeless Veterans, and admissions to the program needs to be available to Veterans who are at risk for homelessness. Preference for admissions must be given to underserved homeless recently discharged from the military, persons living in the community (e.g., shelters, camps), and incarcerated Veterans.

e. **Referrals.** Local policies, procedures, guidelines, and selection criteria must be established to ensure that all applicants for DCHV are adequately screened. DCHV referrals are from VA inpatient and outpatient programs, self-referral, community referral, mail-in application, and referral from the HCHV Program. HCHV is closely aligned with DCHV and may provide homeless outreach for DCHV programs. DCHV programs without access to HCHV need to provide homeless outreach services. Referrals are to be made between DCHV and other MH RRTPs as clinically indicated.

f. **Admission Criteria.** Each DCHV needs to develop local policies, procedures, guidelines, and selection criteria that minimize barriers and maximize access to the program. These policies must conform to the procedures outlined in this Handbook under paragraphs 16 and 17. Humanitarian admissions may be made in special circumstances with the concurrence of the Domiciliary Chief.

g. **Specialized Care and Treatment Modalities.** Specialized care and treatment modalities include:

(1) Evidence-based clinical treatment models (e.g., cognitive behavioral therapy, social skills training).

(2) Evidence-based clinical interventions for medical issues common within this population.

(3) The recovery model emphasizing a holistic approach, empowering the Veteran to participate in decisions regarding care, development of the Veteran's recovery plan, peer support, and utilization of a therapeutic community.

(4) Groups (e.g., psycho-educational, basic living skills, nutrition, money management, basic social skills, vocational, relapse prevention).

(5) Individual counseling.

(6) Case management driven by individualized treatment plans developed with the Veteran.

(7) Programmatic flexibility to successfully address the unique needs of individual Veterans.

(8) Recreation therapy to facilitate resident interaction, leisure planning, and the medical and mental health benefits that accrue from physical activity.

(9) Vocational and Occupational Therapy (e.g., IT, CWT, SE, and community vocational resources).

(10) Access to optical and dental care.

(11) Access to Chaplaincy, Nutrition, and other specialty services.

34. COMPENSATED WORK THERAPY-TRANSITIONAL RESIDENCE (CWT-TR)

a. **Description.** The CWT-TR programs are designed for Veterans whose rehabilitative focus is based on CWT and transitioning to successful independent community living. Ongoing outpatient support is provided for diagnoses-specific conditions. The needs of women Veterans must be addressed, including the expansion of the number of available services and beds available to women Veterans.

b. **Target Population.** The CWT-TR Program was originally implemented and funded with two target populations in mind, the Veteran with severe SUD who frequently relies on institutional care, and the homeless mentally ill Veteran who under-utilizes VA services. During the initial demonstration phase of CWT-TR, this psychosocial rehabilitation model generally limited the targeted Veteran in these populations to Veterans for whom full-competitive employment was an expected outcome. VA leadership has since expanded the CWT-TR target population to include Veterans diagnosed with PTSD and Veterans with serious psychiatric disorders and concomitant vocational deficits. The growing number of homeless women Veterans is considered a population that warrants special focus. Additionally, this expanded authority encourages use of the model for program design and development that maximizes the functional status of Veterans whose level of disability may preclude full employment. The primary objectives for these Veterans are greater independence, improved social status, reduced hospitalization, and community work based on their needs, abilities, strengths, and desires.

c. **Referrals.** CWT-TR referrals are from VA inpatient and outpatient programs, self-referral, community referral, mail-in application, and referral from the HCHV Program. Known

or suspected medical problems that require care must also be identified in the referral. Referral procedures must facilitate access to care and promote timely involvement in the rehabilitation process.

d. **Financial Management Elements**

(1) The CWT-TR legislation authorizes VA to charge Veterans a “Program Fee” to cover the cost of room and board, utilities, and housing maintenance. Money for program fees is derived from a Veteran’s earnings obtained by working in VA’s CWT Program or community employment positions. Program fees are charged primarily to foster increased responsibility of Veterans for their recovery, and only secondarily to defray the cost of maintaining the houses. Each resident, other than the House Manager(s), is required to pay a “TR program fee” to cover costs associated with operational expenses, during the resident’s period of occupancy. These funds must be deposited in a sub-account of the local General Post Fund (GPF) and used only to support the expenses associated with the management and operations of the TR residences. If revenues (program fees) of a residence do not meet the expenses, resulting in an inability to pay actual operating expenses, the medical center of jurisdiction must provide the funds necessary to return the program to fiscal solvency.

(2) Each CWT-TR Program is required to justify the amount of the program fee charged to Veterans. On an annual basis, the CWT-TR Program Manager develops a projected operating budget. On a semi-annual basis, the CWT-TR Program Manager is required to compare the actual program revenues and expenses with the projected budget. If revenues or expenses are over or under projections by more than 5 percent, the Program Manager must take the steps necessary to ensure financial stability. In order to meet this requirement, the medical center’s Chief Financial Officer must provide to the CWT-TR Program Manager a quarterly CWT-TR Budget Report, which contains a beginning balance, total revenues, expenses by cost center, and the ending balance of the CWT-TR GPF account. The CWT-TR Program Manager must provide the quarterly report to the Director, MH RRTP in VACO-OMHS.

e. **Length of Stay (LOS)**. A resident’s LOS in transitional housing does not usually need to exceed 12 months. Veterans with exceptionally complex psychosocial needs or deficits may require a longer LOS to successfully transition to the community. The LOS needs to be based on the measurable goals and objectives listed in the rehabilitation plan. **NOTE:** The CWT-TR program may not be used as a substitute for housing.

f. **Drug and Alcohol Screening**. Residents are prohibited from using or possessing alcohol or illegal drugs while residing in the CWT-TR Program. Residents must agree to regular and random alcohol and drug screenings to ensure a substance-free environment.

g. **Eligibility**. The following criteria apply to CWT-TR admissions.

(1) CWT-TR program eligibility requirements are outlined in 38 U.S.C. § 2032 and further outlined in 38 CFR 17.48.

(2) Veterans must be enrolled in the CWT or SE Programs to be admitted to the CWT-TR houses.

(3) Veterans must be assessed as medication independent under the VHA SMM Program as outlined in Appendix C.

(4) Veterans must be enrolled and working in the CWT Transitional Work Experience (TWE) or SE Program to be admitted to the CWT-TR Program. As Veterans are successful in obtaining community employment or a work opportunity that meets their needs, abilities, strengths, and desires, the Veteran may remain in the CWT-TR house for a period of time necessary to accomplish the goals and objectives listed in the rehabilitation plan and agreed to by the Veteran, program staff, and treatment team. *Note: CWT-TR Programs may not deny admission to veterans who are unable to work full-time.*

h. **Staffing and House Managers.** The CWT-TR residences may be minimally staffed, since by their nature, they are designed to maximize peer support and self-care. However, the safety and welfare of both CWT-TR staff and residents must be the primary consideration. CWT-TRs must maintain a 1:10 staff to bed ratio. When a Veteran is present in the house, on-site supervision of a CWT-TR house is required; a live-in House Manager generally provides this on-site supervision. House Managers may be a senior resident or patient, a graduate of the CWT-TR, or a volunteer. Documented training of the House Managers is required. The House Manager's duties must be outlined in a position description and VA staff must regularly assess the House Manager's performance and competencies. The type of professional staffing provided must be determined by the clinical needs of the Veterans served and by standards applied by external accrediting bodies. Medical center management must identify appropriate staff to be on call by radio, telephone, or pager at all times. A graduate of CWT-TR, acting as a House Manager, must be established as a WOC employee through Human Resources Management Service.

i. **Approval, Acquisition, Code Requirements, and Maintenance**

(1) The CWT-TR Program may operate in a community property that was purchased, leased, or otherwise acquired, or in space on the medical center grounds. Approval to establish a new CWT-TR residence or expand an existing program requires VA Central Office approval through an announced request for proposals (RFP) or by following current policy for bed change requests and MH program changes.

(2) As prescribed by 38 U.S.C. § 2032, in the establishment and operation of a CWT-TR residences, medical centers need to consult with appropriate representatives of the community in which the housing is established and comply with zoning requirements, building permit requirements, and other similar requirements applicable to other real property used for similar purposes in the community. The residence or facility needs to meet community fire and safety requirements applicable to other real property used for similar purposes in the community in which the transitional housing is located; however, fire and safety requirements applicable to buildings of the Federal Government do not need to apply to such property. *NOTE: While Federal fire and safety requirements do not apply to CWT-TR properties, medical centers may choose to follow fire and safety standards from the National Fire Protection Association's Life Safety Code.*

(3) Projected costs for property maintenance, repairs, and replacement of furniture and fixtures, must be integrated into the annual CWT-TR budget. Veterans residing in the houses need to accomplish appropriate minor repairs and maintenance. On-station CWT-TR residences are usually maintained by engineering staff, while community properties may be maintained by engineering staff or community contractors. Medical center management must develop procedures for annual inspections of CWT-TR residences and budget reviews to ensure plans and funds are in place to appropriately maintain these VA housing resources.

35. ESTABLISHING A NEW MH RRTP

a. A proposal to establish MH RRTP care at a given site, whether by new construction, re-designation, or conversion of existing space, must be submitted and approved in accordance with VHA Handbook 1000.1 and MH Program Change policy. Forty beds are considered the minimum size for any DRRTTP or DCHV. However, stand alone MH RRTPs, such as SARRTTP, PTSD-RRTP, PRRTTP, and CWT-TR may operate smaller programs based on patient need and utilization.

b. The feasibility of renovation, re-designation, or conversion of unused or under-utilized inpatient care beds or buildings to a MH RRTP must be fully explored. Proposals for new construction or leased space may be made only if the potential for renovation or redesign is not available at a lower cost. **NOTE:** *Proposals for new construction must adhere to the requirements in VA Handbook 7610 (312).*

c. All proposals are required to:

(1) Identify Veteran populations to be served. Demographic and other population changes having implications for MH RRTP need to be recognized and addressed. For example, the increasing numbers of Veterans needing and receiving care in these programs for psychiatric and substance dependence problems must be acknowledged, as should the growing need for programs addressing issues pertinent to women and to the frail elderly.

(2) Plan programs to meet identified needs.

(3) Include plans for integration of medical, psychiatric, SA, and dental care.

(4) Include plans for serving special populations, such as women, SMI, SUD, OEF/OIF, TBI, incarcerated, and the chronically homeless Veterans. Project a 15 percent minimum utilization rate for women Veterans, if it is a new residential program.

(5) Include staffing levels and patterns.

(6) Identify resources needed to achieve the desired goals and objectives to accommodate both male and female Veterans on-site or in the community.

(7) Include start-up and recurring costs.

(8) Identify the space to be utilized.

d. All proposals must recognize the paramount importance of creating MH RRTPs that emphasize the provision of care in a safe, secure, and sober environment. Accordingly, attention must be paid to issues of facility security, control of Veteran and non-Veteran ingress and egress, infection control, disaster plans, procedures for the detection of weapons, drug and alcohol use, and the provision of appropriate medical care.

e. Plans must include effective communications systems to ensure that assistance can be immediately sought and readily provided in case of emergency. Such systems must be attentive to both personnel (numbers, types, proximity of staff or other support personnel) and technological issues (reliable means to communicate, even in extreme circumstances).

f. All proposals need to address academic affiliations, as well as any prospective roles of MH RRTP, or any associated medical center staff, in training, education, and research.

g. All proposals for the creation of DCHV Programs, or proposals for the establishment of a DCHV Program within an existing DRRTP, must support and complement other VA initiatives targeted to homeless Veteran populations and must be integrated with existing coalitions of public agencies and volunteer organizations working with the homeless.

36. CHANGES IN PROGRAM STRUCTURE, STAFFING, MISSION, OR BED CAPACITY

Changes in MH RRTP structure, mission, number of beds, number of staff, or program capacity must follow current VHA bed control policy along with the MH program change policy. The planning for changes to MH RRTPs must include a VISN- level review to ensure that access and coordination of mental health and SUD services are maintained throughout the VISN. Medical centers must consult with the OMHS prior to the submission of the program or bed change request as outlined in current VHA bed control policy and current VHA MH program change policy.

37. REFERENCES

- a. VHA Directive 1000.1.
- b. VHA Handbook 1907.1.
- c. VHA Handbook 1160.01.

CORE STAFFING REQUIREMENTS

1. Minimum Core Staffing Requirements

a. Mental Health (MH) Residential Rehabilitation Treatment Programs (RRTP) are required to maintain adequate staffing to provide safe, appropriate clinical care. The staffing pattern for nursing personnel must be based on common and unit-specific workload indicators such as: unit turbulence (gains, losses, and turnover rate); scope and complexity of services, such as medication management, validated competencies, skill mix, ancillary support, environmental considerations, nursing hours per patient day (NHPPD); and staff replacement calculations.

b. The staffing pattern for other disciplines is to be based on a bed to staff ratio and at a minimum contain the staff positions in the following table which provide an example of a 40-bed program for all disciplines other than nursing:

Minimum Core Staffing Requirements (40 Bed Example)

Position	Full Time Equivalent (FTE)	Description
(1) Domiciliary Chief or MH RRTP Program Manager	1.0	All Domiciliary Residential Rehabilitation Treatment Programs (DRRTP) and Domiciliary Care for Homeless Veterans (DCHV) must have a full time Domiciliary Chief. All other MH RRTPs must have a designated Program Manager
(2) Assistant Domiciliary Chief or MH RRTP Clinical Manager	0.0	MH RRTPs with 100 or more beds require an Assistant Domiciliary Chief or MH RRTP Program Manager to provide administrative back-up to the Domiciliary Chief and clinical supervision of specialty units.
(3) 24-hour-per-day, 7-days-per-week (24/7) Coverage Staff	6.0	6.0 FTE is the minimum staff necessary for a <u>single unit</u> to cover the sixteen off-tour shifts. Additional coverage staff are necessary for units on separate floors or in separate buildings. Coverage staff may be comprised of any combination of Rehabilitation Technicians, Health Technicians, Nurses Aids, Domiciliary Assistants, Peer Technicians, Addiction Technicians, Licensed Practical Nurses (LPN), or Licensed Vocational Nurses (LVN). It is recommended that in addition to covering evening, night, and weekend shifts, some of these positions be allotted to regular business hours, as these individuals play a vital role in the establishment and maintenance of a healthy therapeutic milieu. In medically-supervised units, the coverage staff may need to be comprised primarily of LPNs or LVNs in order to dispense medications on all shifts.

Position	Full Time Equivalent (FTE)	Description
(4) Doctor of Medicine (MD), Physicians Assistant (PA), Nurse Practitioner (NP)	0.5	Provides medical care including admission orders, history and physical (H&P), discharge orders, sick call and medication orders. Coordinates referrals and oversees continuity of medical care. PAs and NPs must be under direct clinical supervision of an MD.
(5) Psychiatrist	0.4	Provides psychiatric care including medication management, assessments, referrals, and crisis intervention. The psychiatrists may also provide components of the medical care (see (4)).
(6) Psychologist	0.8	Provides psychological assessments and psychotherapeutic interventions.
(7) Nursing Personnel (Registered Nurses (RNs), LPNs or LVNs, and Nursing Assistants (NAs))	1.0 or NHPPD-dependent	RNs assess patients, establish and monitor the plan of care including the medication management of the individual's rehabilitation needs, and provide staff education as appropriate. Some medically-supervised units may need to be comprised primarily of LPNs or LVNs so that they may dispense medications on all shifts. NAs provide nursing care as directed by the plan of care.
(8) Social Worker	1.6	Provides psychosocial assessment, case management, group and individual counseling, and discharge planning.
(9) Peer Technician	0.4	Provides peer support, mentoring, and counseling.
(10) Recreation Therapist	0.3	Provides treatment services, assessments, and therapeutic recreation activities.
(11) Dietician	0.3	Provides nutritional assessments, counseling, and education.
(12) Pharmacist	0.5	Provides medication assessments, counseling, and education as outlined by the self medication policy. Pharmacy technicians may be substituted when appropriate.
(13) Medical and Program Support Assistant	1.0	Provides ward clerk, evaluation, and administrative functions.

2. MH RRTPs must maintain the following staff to bed ratio:

- a. For programs up to 40 beds: A ratio of 1:3.
- b. For programs 40 too 100 beds: A ratio of 1:4.
- c. For programs over 100 beds or Health Maintenance Domiciliary beds: A ratio of 1:5.

NOTE: MH RRTPs may be required to adjust individual clinical staff ratios to reflect the mission of the program and the needs of the Veterans served. Medical centers may make the adjustment as long as they continue to meet the staffing to bed ratio. Where special circumstances warrant, medical centers may request a waiver from the staff to bed ratio or prescribed staffing pattern. Written requests for waivers must be submitted to the Director, Residential Rehabilitation and Treatment Programs, Office of Mental Health Service (OMHS), Department of Veterans Affairs (VA) Central Office. The request for waiver needs to describe the medical center’s plan for providing appropriate milieu security and access to appropriate services utilizing the requested staffing ratio or pattern.

3. MH RRTPs maintain the following minimum Core Staffing based on number of beds. NOTE: Additional staffing may be necessary based on the factors listed in following paragraph 5.

Minimum FTE by Number of Beds

Position per Beds	Less than (< 20	21-30	31-40	41-50	51-60	61-80	81-99	100-125	126-150	150-175	176-200
Chief or Manager	0.5	0.5	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Assistant Chief or Clinical Manager	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0	1.0	1.0	1.0
24/7 Coverage	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0
MD, PA, or NP	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.6	1.9	2.2	2.5
Psychiatrist	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.5	1.8	2.0
Psychologist	0.4	0.6	0.8	1.0	1.2	1.6	2.0	2.6	3.0	3.6	4.0
Nurse	0.5	0.8	1.0	1.3	1.5	2.0	2.5	3.1	3.8	4.4	5.0
Social Worker	0.8	1.2	1.6	2.0	2.4	3.2	4.0	5.0	6.0	7.0	8.0
Peer Tech	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.3	1.5	1.8	2.0
Recreation Therapist	0.2	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.2	1.4	1.6
Dietician	0.2	0.2	0.3	0.4	0.5	0.6	0.8	1.0	1.2	1.4	1.6
Pharmacist	0.3	0.3	0.5	0.5	0.6	0.75	1.0	1.0	1.2	1.4	1.6
Medical or Program Assistant	0.5	0.8	1.0	1.3	1.5	2.0	2.5	3.1	3.8	4.4	5.0
Total FTE	10.0	11.5	13.6	15.4	17.1	20.2	23.7	29	33.1	40.4	41.3
Staff to Bed Ratio	0.50	0.38	0.34	0.30	0.28	0.25	0.23	0.23	0.22	0.23	0.20

NOTE: Programs over 200 beds need to contact the Director, MH RRTP, OMHS, VA Central Office for directions on developing a staffing plan by using a combination of bed columns.

4. Factors Affecting the Minimum Core Staffing. The following factors increase the minimum core staffing required for MH RRTPs. These factors must be considered when developing the written staffing plan.

(a) Number of beds. MH RRTPs with 20 or fewer beds must staff the units at the 20-bed level as this is considered the floor or minimum staff necessary to maintain a safe and effective program.

(b) Distribution of beds (one or multiple units).

(c) Medication management procedures (nursing staff for administration and monitoring).

(d) Length of stay (LOS), (shorter LOS increases workload due to increased turnover).

(e) Location and type of residential facility (travel distance, transportation logistics).

(f) Client demographics (diagnosis, acuity, recovery time, etc.).

(g) Cultural maturity of program (strength of peer support, degree of “built-in” programming structure, experienced use of policies and procedures, etc).

5. Additional Vocational Rehabilitation Minimum Staffing Requirements (40 Bed Example).

Position	FTE 40 Beds	Description
Vocational Specialty Staffing	1.33	Provides vocational and employment-related assessments, education, group and individual counseling, job development, and placement.

6. Specialty Bed Section Staffing Requirements. Specialty beds sections such as Substance Abuse Residential Rehabilitation Treatment Programs (SARRTP), Post-Traumatic Stress Disorder (PTSD) RRTP, and Psychosocial RRTP’s (PRRTP) require additional specialty staff as outlined in subparagraphs 5a, 5b, 5c, and 5d. Each MH RRTP must base the number of Specialty Staffing on the number of Specialty beds assigned to the program. In “All Inclusive” RRTP models, these staff are assigned directly to the unit. In “Supportive Residential” RRTP models, these staff may be part of medical center outpatient clinics, such as: Substance Abuse Treatment Programs (SATP), PTSD Treatment Programs, Psychosocial Rehabilitation and Recovery Centers (PRRC), or Compensated Work Therapy (CWT) programs. The outpatient specialty staff is to be fully-participating members of the MH RRTP treatment team including the screening, assessment, and treatment planning process.

a. Additional PTSD-RRTP Minimum Staffing Requirements (40 Bed Example)

Position	FTE 40 beds	Description
PTSD Specialty Staffing	5.0	Provides primary PTSD-related assessments, education, group, and individual counseling.

b. Additional SARRTP Minimum Staffing Requirements (40 Bed Example)

Position	FTE 40 beds)	Description
Substance Use Disorder (SUD) Specialty Staffing	5.0	Provides primary SUD-related assessments, education, group, and individual counseling.

c. Additional Seriously Mentally Ill Minimum Staffing Requirements (40 Bed Example)

Position	FTE 40 beds	Description
Seriously Mentally Ill (SMI) Specialty Staffing	5.0	Provides primary SMI-related assessments, education, group, and individual counseling.

d. MH RRTP Specialty Staffing Requirement Based on the Number of Beds

Position per Bed	<20	21-30	31-40	41-50	51-60	61-80	81-99	100-125	126-150	150-175	176-200
PTSD-RRTP Specialty Staff	2.5	3.8	5.0	6.3	7.5	10	12.5	15.6	18.8	21.9	25
SARRTP Specialty Staff	2.5	3.8	5.0	6.3	7.5	10	12.5	15.6	18.8	21.9	25
SMI-PRRTP Specialty Staff	2.5	3.8	5.0	6.3	7.5	10	12.5	15.6	18.8	21.9	25
Psychosocial Rehabilitation, Vocational Rehabilitation Specialty Staff	0.7	1.0	1.3	1.7	2.0	2.7	3.3	4.2	5.0	5.8	6.7

**CORE MINIMUM COMPENSATED WORK THERAPY (CWT) - TRANSITIONAL RESIDENCE (TR) STAFFING
REQUIREMENTS AND CONSIDERATIONS**

1. CWT-TR Staffing generally describes the direct staff assigned to ensure provision of the residential component of the CWT-TR episode of care. CWT-TR programs must maintain a staff to bed ratio of 1:10. The CWT-TR direct staffing usually consists of a matrix which provides the following services:

Position	Full Time Equivalent (FTE) Per 10 beds	Description
a. Program Manager	0.15	Administrative Program Management (e.g., program review, reporting, and analysis; financial and facilities management; policy and procedures; incident reporting; safety measures; outcomes management). <i>NOTE: Duties can be assigned to the Case Manager.</i>
b. Care Manager	0.5	(1) Coordinating assessment, screening, treatment, and discharge planning, etc. (2) Individual case management. (3) Clinical Program Management (e.g., service planning, clinical program interface, community services coordination). (4) Therapeutic residential group meetings and activities.
c. Program Clerk	0.15	Ward clerk functions, processing program bills for payment, etc.
d. Doctor of Medicine (MD), Physicians Assistant (PA), Nurse Practitioner (NP)	0.05	Write admission and discharge orders, history and physical's (H&P), discharge summary, etc.
e. Program Evaluator	0.15	Program data collection, monitoring and follow-up. <i>NOTE: Duties can be assigned to the Case Manager.</i>
f. Other clinical resources	0.05	Chaplain, Occupational Therapy, Dietitian, and other clinical staff providing independent living skills, and other group meetings and activities.

NOTE: This ratio does not include; responsibilities associated with operations of CWT programming, or primary responsibility for vocational service delivery; or responsibilities for primary care, substance abuse, or mental health services.

2. **Factors Affecting CWT-TR Staffing Demands.** The following factors increase the core minimum staffing required for a CWT-TR program. These factors must be considered when developing the written staffing plan.

- a. Number of Beds.

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b. CWT-TRs with ten or fewer beds must staff the program at the ten-bed level, as this is considered the floor or minimum staff necessary to maintain a safe and effective program.

c. Distribution of beds (one or multiple sites).

d. Location and type of residential facility (travel distance, transportation logistics).

e. Veteran demographics (e.g., diagnosis, acuity, recovery time).

f. Cultural maturity of residence (strengths of peer support, degree of built-in programming structure, experienced use of policies and procedures, etc.).

g. Staff skills, competencies, and cohesiveness.

h. Type, number, and utilization of House Managers.

i. CWT-TR Minimum Staffing Based on Number of Beds

Position per Bed	Less than 10	11-15	16-20	21-25	25-30	31-35	35-40	40-45
(1) Program Manager	0.2	0.2	0.3	0.4	0.5	0.6	0.7	0.8
(2) Care Manager	0.5	0.8	1.0	1.3	1.5	1.8	2.0	2.3
(3) Program Clerk	0.2	0.2	0.3	0.4	0.5	0.5	0.6	0.7
(4) MD, PA, or NP	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8
(5) Program Evaluation	0.2	0.2	0.3	0.4	0.5	0.5	0.6	0.7
(6) Other Clinical	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8
Total FTE	1.1	1.8	2.5	3.3	4.0	4.6	5.3	6.1

3. Staff Tours of Duty and Call Back Coverage. CWT-TR is a work-based residential rehabilitation program. Veterans are required to work during their TR experience. In most instances (and ideally) these Veterans work day shifts, and interruptions to their work assignments needs to be minimized to the greatest extent possible. Therefore, residential components of the program (e.g., house meetings, individual and group therapy, life skills training, and Northeast Program Evaluation Center (NEPEC) interviews) need to take place in the evening hours (usually between 5:00 p.m. and 8:30 p.m). Staff tours of duty need to be established primarily to accommodate the needs of the Veterans served and secondarily staff tours of duty. Regular or as-needed Department of Veterans Affairs (VA) staffing for weekend tours need to be planned for and periodically reassessed.

4. 24-Hour Staff Availability. A member of the TR staff needs to be available for "call-back" at all times. This does not mean that someone must always carry a pager and always be available. What it does mean is that a cascading callback system needs to be in place. This system needs to include appropriate VA medical center personnel for the instances where no TR staff can be immediately contacted.

MEDICATION MANAGEMENT

1. Veterans Health Administration (VHA) has shifted health care delivery from traditional inpatient hospital-based approaches to a range of residential and community-based delivery systems. This shift has fostered a greater emphasis on rehabilitative approaches that promote Veteran education and skill development designed for improved self-care. With these newer approaches to health care, Veterans are able to learn and practice self-care skills, including self-management of their medication regimens.

2. Veterans in Mental Health (MH) Residential Rehabilitation Treatment Programs (RRTP) are able to learn and practice safe management of their medication regimens in order to achieve independent medication administration. Each Domiciliary Chief or MH RRTP Program Manager must develop a local policy for Safe Medication Management (SMM) within the unit. *NOTE: VHA Handbook 1108.3, Self Medication Program does not apply to MH RRTPs.*

3. In MH RRTPs, the level of independence for medication management for each Veteran must be assessed as dependent, semi-independent, or independent. Veterans who are otherwise appropriate and eligible for admission to a MH RRTP may not be denied access based on a dependent or semi-independent assessment. Veterans also may not be denied based on prescription of controlled medications.

a. The dependent Veteran requires additional education and varying levels of medication supervision, which includes direct involvement of nursing for observing and administering each medication. The MH RRTP must follow the protocol as outlined in VHA Handbook 1108.06, for Veterans categorized as dependent.

b. The semi-independent Veteran is able to assume partial responsibility for storage, security, and safe administration of medications. These Veterans require varying degrees of supervision; professional staff may assume an indirect role in the veteran's medication management by documenting the results of periodic reviews of Veteran's safe medication practices, a visual count of Veteran's medications, or clinical observations of their responses to medications. The MH RRTP may utilize a combination of services outlined in VHA Handbook 1108.06 and VHA Handbook 1108.05, for Veterans assessed as semi-independent.

c. The independent Veteran is able to assume complete responsibility for the storage, security, and safe administration of medications. Controlled substances must be administered to veterans assessed as independent. However, in the last one-third of veterans length of stay and with at least two consecutive reassessments as independent, the independent veteran may be prescribed up to a 7-day supply for self-administration. This Veteran understands the purpose of each medication with a general understanding of their common side effects, and can consistently demonstrate independent medication management. The MH RRTP may utilize a combination of services outlined in VHA Handbook 1108.06 and VHA Handbook 1108.05, for Veterans assessed as independent. *NOTE: All controlled substances must be administered and recorded by licensed staff, except in Compensated Work Therapy (CWT) - Transitional Residence (TR) Program. Specific medications or local policy may dictate more restrictive prescribing practices similar to controlled substance for a broader range of medications. However, otherwise*

appropriate and eligible Veterans are not to be denied access to MH RRTP's based on these local prescribing practices.

4. A Veteran's ability to safely manage medications must be assessed by the Doctor of Medicine (MD), Physicians Assistant (PA), Nurse Practitioner (NP), Clinical Pharmacist, Clinical Nurse Specialist (CNS), or registered nurse (RN) upon admission into an MH RRTP. The Veteran must be assessed for independent, semi-independent, or dependent medication management. Proper documentation must include a progress note along with a provider's order. This assessment must be documented in the Veteran's medical record by the staff member(s) completing the assessment. This assessment must include the Veteran's degree of knowledge and understanding of the following:

a. **SMM.** This includes:

- (1) The name of each medication;
- (2) How to administer each medication (such as appropriate frequency, routes of administration, dose);
- (3) Security requirements;
- (4) Reason for taking each medication; and
- (5) Common side effects of the medication.

b. **Assessment.** Physical and cognizant assessment as it relates to managing medications, to include:

- (1) Integration of medications into the Veteran's lifestyle;
- (2) Possible barriers to compliance;
- (3) Possible barriers to learning; and
- (4) Procedures for requesting a change in medication regimen.

5. SMM must be incorporated into an individual treatment plan for each Veteran in the MH RRTP and must be reviewed as part of updates. Treatment plans need to identify those Veterans with a past history of high-risk medication behavior (suicide attempts with overdoses, treatment resistance, etc.) or those prescribed high-risk-alert medications. Due to the increased complexity of MH RRTP Veterans, a pharmacist must be available to participate on the treatment team. The variation in drug distribution and dispensing required to support MH RRTPs requires augmentation of pharmacy staff in order to achieve program goals.

NOTE: Indicators that pharmacy and provider consultation may be required, examples include; controlled substances, history of medication misuse, high-risk behaviors, and high-risk high-alert, psychopharmacologic, and investigational medications.

6. Clinical monitoring dictated by individual treatment plans must include the Veteran's response to medications.

a. This monitoring must be evaluated and recorded in the Veteran's medical record as defined in the treatment plan at least monthly. This applies to all Veterans regardless of SMM level. **NOTE:** Medication monitoring in MH RRTP's is in addition to medical center medication reconciliation policy.

b. Clinical monitoring needs to include:

(1) Identification of target symptoms;

(2) Evaluation of the efficacy of the medication on those target symptoms and of any adverse events associated with the use of the medication, including the Veteran's own perception about side effects and efficacy;

(3) Reviewing relevant laboratory results; and

(4) An evaluation of educational needs and barriers.

7. Licensed staff responsibility for monitoring the Veteran's safe management of medications may range from directly observing and documenting each dose to: observation of a Veteran filling a daily pillbox or counting the medication in the Veteran's possession; clinical monitoring; and documentation of the Veteran's response to the medication. Each Domiciliary Chief or MH RRTP Program Manager must define the responsibilities for documentation in their local SMM policy.

8. In cases where a Veteran is assessed as dependent or semi-independent, or is prescribed controlled substances, appropriately-licensed staff must be available to administer or monitor medications for Veterans in the MH RRTP. Veterans' ability to manage their own medications can change throughout their treatment.

a. **First Dose Monitoring.** MH RRTPs must have a process to monitor a Veteran's response to the first dose(s) of a new medication, as clinically indicated. Monitoring must be performed by a registered nurse, or other appropriate medical provider. **NOTE:** Appropriate first dose monitoring is determined by the medication and the individual; medical providers responsible for the monitoring may be licensed providers within the MH RRTP or licensed staff in any VHA clinic area.

b. **Periodic Reassessment of Veteran Medication Management.** Assessment of the Veteran's medication knowledge is a process by which a Veteran's ability to accurately and safely manage the medication regimen is determined. Reassessment must take place as deemed

appropriate by the medical provider, but at least monthly, and all findings documented in the Veteran's medical record.

c. **Level of Medication Management.** There are three levels of medication management in SMM: dependent, semi-independent and independent (see par. 3 of this Appendix). Staff assessment of the Veteran's ability may indicate the progression towards increasing independence or regression towards decreasing independence. When independent SMM status is reached, a Veteran may receive up to 30-day supply for all medications prescribed with the exception of controlled substances.

9. A Veteran's education and thorough understanding of prescribed medications are vital to the Veteran's success in managing medication(s).

a. An initial assessment of the Veteran's knowledge of the Veteran's medication(s) must be performed and documented upon admission by the MD, PA, NP, Clinical Pharmacist, CNS, or RN.

b. Following an initial assessment of the Veteran's medication regimen, education must be provided by clinical staff for each of these prescribed medications, regardless of the level of Veteran independence. **NOTE:** *The use of learning aids may be beneficial and is encouraged for increased comprehension and compliance with the medication regimen. Examples could include a demonstration of proper metered dose inhaler technique, daily flow sheets of medications and administration times, posters, and the use of an assistive device (e.g., a pill box). Most Veterans on more than three medications per day benefit from the use of an assistive device. The use of an assistive device must not determine the Veteran's level of independence.*

10. Documentation of the Veteran's education by the staff member(s) providing the training must be included in the Veteran's medical record. Such documentation includes:

a. The name of person providing education;

b. Education provided;

c. A demonstrated level of understanding and verbalization by the Veteran; and

d. An evaluation of a Veteran's learning needs (e.g., barriers, preferred methods of learning, etc.).

11. MH RRTP's must follow Pharmacy Service policies and conform to The Joint Commission (TJC) and Commission on Accreditation of Rehabilitation Facilities (CARF) standards for medication management. **NOTE:** *Related documents supporting the medication management include: VHA Handbook 1108.06, VHA Handbook 1108.05, VHA Handbook 1108.01, and VHA Handbook 1108.2. NOTE: VHA Handbook 1108.3, does not apply to MH RRTPs.*

12. Each Domiciliary Chief or MH RRTP Program Manager must develop a local SMM policy that outlines procedures for the securing, administration, monitoring, assessment, and education

of medications in accordance with VHA and accrediting body standards for medication management.

13. All medications managed by the Veteran must be secured in a locked cabinet, drawer, locker, or other acceptable secured means accessible only to the Veteran, the provider with prescriptive privileges, or qualified program staff. Keys or codes must be unique to each Veteran's locked area.

a. Local policy to address Veterans' demonstrating difficulty in safely securing medication must be established.

b. Interventions to assist Veterans in understanding the importance of safely securing medications may include, but are not limited to: incentives for demonstrated safe practice, clinical contracts, regular and random room inspections to ensure safe medication storage, and educational interventions. **NOTE:** *Every effort to ensure a safe environment for Veterans must be emphasized.*

(1) Exceptions to Veteran security requirements made for medication(s) that must be stored under secure refrigerated conditions, must be in accordance with local policy.

(2) Veterans must agree, in writing, to comply with all MH RRTP security requirements. This agreement must include a statement that the Veteran is responsible for the security of medication(s) in a designated locked area with security code or key issued to the Veteran.

14. Medication reconciliation procedures are a key element of the SMM assessment. At a minimum, reconciliation should occur upon admission to the unit, any time the medication orders are rewritten and/or any time the Veteran changes service, setting, provider or level of case care. Documentation by the MD, PA, NP, Clinical Pharmacist, CNS, or RN that reflects medication reconciliation must be included in the Veteran's medical record. Each Domiciliary Chief or MH RRTP Program Manager must fully participate in the medical center's on-going medication management quality improvement and monitoring efforts including medication error reporting.

15. Each Domiciliary Chief or MH RRTP Program Manager is responsible for ensuring that all controlled substances are administered by a licensed practitioner, except in CWT-TR Program, as outlined in VHA Handbook 1108.06 and VHA Handbook 1108.01.

a. Each Domiciliary Chief or MH RRTP Program Manager must:

(1) Develop a local written policy for the storage, administration, and monitoring of prescribed controlled substances, which meets VHA and accrediting body standards for medication management.

(2) Ensure that all providers adhere to Substance Abuse and Mental Health Services Administration (SAMSHA) guidelines for prescription of Buprenorphine for Detoxification.

(3) Ensure that controlled substances administered to Veterans by licensed independent practitioners are managed in accordance with local medical center policy and Handbook

1108.01. **NOTE:** *The medication process is more labor intensive than routine inpatient medication dispensing formats and therefore is not to be utilized to solve staffing or related- workforce issues. Medical center Directors must ensure that clinical services, such as pharmacy and nursing are augmented to properly manage this patient population.*

(4) Ensure that Veterans are assessed as medication independent to be admitted and remain in the CWT-TR Program. Medication management in CWT-TR Program is based on the SMM Program with a limit of 7-day quantity, or less, for controlled substances.

(5) Ensure that when controlled substances are prescribed to a Veteran, residing in a MH RRTP (except for CWT-TR), they are administered as a single dose and monitored by appropriately-licensed staff assigned directly to the MH RRTP or by integrating controlled substance administration utilizing medical center clinics, programs, or units. **NOTE:** *Exceptions are noted in subparagraphs 15b(1) and 15b(3).*

b. Exceptions to the controlled substances policy include:

(1) Authorized absences as a means to meet rehabilitation goals, for example: employment, community integration, establishment of relationships with family and friends, and participation in recreational activities. The process for obtaining pass medications and controlled substances must comply with VHA Handbook 1108.05. Medications intended for self administration when Veterans are on authorized absence, must be labeled and dispensed as a prescription(s), by a pharmacist. Controlled substance prescriptions for authorized absences must be limited to a 7-day quantity or less.

(2) Veterans returning from an authorized absence who were provided with pass medications need to be evaluated by licensed staff; medication must be inventoried and medication use documented in the medical record. Any excess pass medication must be returned to the pharmacy according to local medical center policy. **NOTE:** *A process for ensuring chain of custody for controlled substances must be established through local policy.*

(3) Veterans in later stages of treatment and preparing for transition to the community with prescribed controlled substances need to be assessed for independence in managing these medications. If the Veteran is deemed appropriate, controlled substances may be dispensed to the Veteran for self-medication in 7-day quantities, or less. SMM must be continued during the community reintegration phase, to include: assessment, re-assessment, monitoring, evaluation, and documentation.

16. Prescription, Over-the-Counter (OTC) Medications and Herbal Products. Medications prescribed by outside providers, OTC medications and herbal products are permitted in MH RRTP's only after a VHA licensed prescriber has evaluated the Veteran's medical history, medication regimen, and approved the products for use. **NOTE:** *If a medical center elects to allow the patient to bring OTC's or medications prescribed by outside providers, then it must be*

defined in local policy. In these instances all items must be verified and re-labeled by pharmacy service prior to their use.

17. Chart Assessing a Patient's Medication Knowledge.

Key Functions	<u>Level I</u> "DEPENDENT" Zero or limited knowledge or understanding of medical regimen.	<u>Level II</u> "SEMI-INDEPENDENT" Incomplete knowledge of all medication(s).	<u>Level III</u> "INDEPENDENT" Functional knowledge of all medication(s).
Pharmacy method of dispensing	Individual dose.	1-30 day multiple-dose vial of some to all medications.	Multiple-dose vial of all medications.
Means of medication receipt	Nurse to administer all medication.	A combination of Nurse administration and independent dosing.	Independent self-administration (except controlled substances).
Monitoring of medication management, education, and documentation of administration	Nurse administration of all medication and documentation of ongoing patient education.	Nurse may administer individual dose administration or supervise filling of medication boxes for self administration of some medications, and document compliance.	At least monthly reassessment, clinical monitoring, and documentation of compliance.
Patient Education	Reinforcement of education at each dosing.	Initial education with periodic review of knowledge.	Initial education with periodic review of knowledge.
Responsibility for medication storage	Program storage of <u>all</u> medication.	Program storage of select medication and patient storage of medications in a locked location.	Patient stores own medications in a locked location, except controlled substances.
Controlled Substances	Nurse Administration <i>Exception is noted in subparagraph 15b(1).</i>	Nurse Administration <i>Exception is noted in subparagraph 15b(1).</i>	Nurse Administration, except CWT-TR. <i>Exceptions are noted in subparagraph 15b(1), and 15b(3).</i>